



### Getting to Know You

Patient Name \_\_\_\_\_  
Mailing Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Physical Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_  
Cell Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Email \_\_\_\_\_  
Social Security Number \_\_\_\_\_  
Birthdate \_\_\_\_\_  Male  Female  
Driver's License # \_\_\_\_\_  
Employer \_\_\_\_\_

### How did you hear about our office?

\_\_\_\_\_

**If a friend or family member referred you, we would like to thank them. To whom may we send our thanks?**

\_\_\_\_\_

### Communication

Which of the following are methods we can contact you for appointment confirmations and other office communications? Check all that apply.

Text  Email  Phone  Mail

### Financially Responsible Party

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

### Emergency Contact

Name \_\_\_\_\_  
Relationship \_\_\_\_\_  
Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

### Dental Insurance Information

Insured's Name \_\_\_\_\_  
Relationship to Patient \_\_\_\_\_  
Birthdate \_\_\_\_\_  Male  Female  
Employer \_\_\_\_\_  
Work Phone \_\_\_\_\_  
Insurance Carrier \_\_\_\_\_  
Ins. Co Address \_\_\_\_\_  
City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_  
Policy/ID # \_\_\_\_\_  
Group # \_\_\_\_\_

### Consent

I hereby authorize the performance of dental services upon the above-named patient and whatever procedures the judgement of the doctor may decide in order to carry out these procedures. I understand that the initial visit requires x-rays in order to complete the examination, diagnosis, and treatment plan. I authorize and request the administration of any x-rays and local anesthetics as deemed necessary and advisable by the doctor. I also authorize assignment of my insurance benefits directly to the provider for services rendered. I fully understand that I am responsible for all charges to my account regardless of the decision of my insurance company to pay or deny for any reason.

**X**

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date



## Patient Health History

Patient Name: \_\_\_\_\_ Date \_\_\_\_\_

### Medications

Please list **ALL** medications or supplements you are currently taking:

Med _____	For _____
Med _____	For _____
Med _____	For _____
Med _____	For _____
Med _____	For _____
Med _____	For _____

Have you ever taken a bisphosphonate medication (e.g. Fosamax, Boniva)?  Yes  No

### Medical History

Physician's Name \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_

Date of last exam \_\_\_\_\_

Have you ever been hospitalized?  Yes  No

Reason? \_\_\_\_\_

(Women) Are/could you be pregnant?  Yes  No

(Women) Are you nursing?  Yes  No

Please check if you have or have had any of the following medical conditions:

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Rheumatic Fever         | <input type="checkbox"/> Arthritis                  | <input type="checkbox"/> Lung Disease                              |
| <input type="checkbox"/> Heart Murmur            | <input type="checkbox"/> HIV Positive/AIDS          | <input type="checkbox"/> Breathing Problems                        |
| <input type="checkbox"/> Mitral Valve Prolapse   | <input type="checkbox"/> Venereal Disease           | <input type="checkbox"/> Tuberculosis (TB)                         |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Blood Transfusion          | <input type="checkbox"/> Psychiatric Treatment                     |
| <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Heart Valve Replacement    | <input type="checkbox"/> Aspirin/Anticoagulant Therapy             |
| <input type="checkbox"/> Low Blood Pressure      | <input type="checkbox"/> Heart Problem (_____)      | <input type="checkbox"/> Ulcers or Stomach Problems                |
| <input type="checkbox"/> Any Type of Transplant  | <input type="checkbox"/> Dialysis                   | <input type="checkbox"/> Any type of Implant                       |
| <input type="checkbox"/> Drug Addiction          | <input type="checkbox"/> Chemotherapy               | <input type="checkbox"/> Cancer (Type: _____)                      |
| <input type="checkbox"/> Alcoholism              | <input type="checkbox"/> Radiation Treatment        | <input type="checkbox"/> Any Artificial Hip, Knee, or other Joint  |
| <input type="checkbox"/> Use of Tobacco Products | <input type="checkbox"/> Thyroid Disease            | <input type="checkbox"/> Other medical condition not listed: _____ |
| <input type="checkbox"/> Hepatitis (Type: _____) | <input type="checkbox"/> Epilepsy or Seizures       | _____  |
| <input type="checkbox"/> Liver Disease           | <input type="checkbox"/> Fainting or Dizzy Spells   | _____  |
| <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Pace Maker / Heart Surgery | _____  |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Sinus Problems             |  |
| <input type="checkbox"/> Allergies or Hives      | <input type="checkbox"/> Excessive Bleeding         |  |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Stroke                     |  |

Do you have any of the following allergies?

Seasonal  Ibuprofen  Penicillin  Codeine  Latex  Local Anesthetics  Other Medications

Please list any other allergies: \_\_\_\_\_

**X** \_\_\_\_\_ Date \_\_\_\_\_

Patient / Guardian Signature

Date



## Dental History

What is your main goal for today's visit?

\_\_\_\_\_

When was your last dental exam?

\_\_\_\_\_

How often do you have your teeth cleaned?

\_\_\_\_\_

Do you have any pain in your mouth? Where?

\_\_\_\_\_

Do you have any pain of the TMJ?

\_\_\_\_\_

What do you like most about your smile?

\_\_\_\_\_

What would you change about your smile?

\_\_\_\_\_

What did you like about your previous dentist?

\_\_\_\_\_

What did you dislike about your previous dentist?

\_\_\_\_\_

Are you interested in whitening your teeth?

\_\_\_\_\_

Are you interested in straightening your teeth?

\_\_\_\_\_

Do you clench or grind your teeth? When?

\_\_\_\_\_

Do you snore or been told that you snore?

\_\_\_\_\_

Do you frequently have mouth sores or growths?

\_\_\_\_\_

Have you been told to take antibiotics prior to dental treatment? \_\_\_\_\_

I understand that the information I have provided on these forms is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be necessary, you have my permission to request that information from the respective health care provider and for them to release the information to you. U promise to notify the doctor of any change in my health or medication.

**X**

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date



## **Financial Agreement**

Patient Name: \_\_\_\_\_

### **Financial Policies and Acknowledgments**

We believe that all patients deserve to know, up front, our financial policies. Below are our policies relating to your dental care.

### **Payment**

Your estimated portion is due in full as services are rendered. For your convenience, we accept cash, checks, debit cards, and credit cards. We also offer third party financing. Arrangements for financing through a third party must be made in advance of your appointment. Accounts with returned checks due to insufficient funds will be assessed a \$30 fee

### **Dental Insurance**

As a courtesy, we will file your primary insurance claim for you. We offer this service to you as a courtesy only, and it is not meant to be a substitute for payment. We will attempt to collect from your insurance carrier, their portion of the charges for your visit. We cannot guarantee that they will pay any amount for your treatment. Each plan has different exclusions and limitations and those exclusions and limitations change over time. Our office recommends dental treatment based on medical necessity and not on whether your insurance company will cover a procedure. It is your responsibility to know your dental coverage. It is your responsibility to pay any amount not covered by your insurance company regardless of the reason. We will instruct your insurance carrier to send all payment directly to our office for reimbursement. In the event that an insurance company sends payment directly to you, the payment must be forwarded/assigned to our office.

### **Missed Appointment Fee**

Our office requests 24 hours advance notice if you are unable to keep your scheduled appointment. If less than 24 hours notice is given, a \$30.00 fee will be charged to your account. Patients with three or more missed appointments may be assisted in finding dental care from another doctor.

### **Emergency/After Hours Care**

If you or your child is seen for an emergency visit after regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

### **Past Due Accounts**

If your account becomes past due, we will take necessary steps to collect this debt. If we refer your account to a collection agency, you agree to pay all collection costs which are incurred.

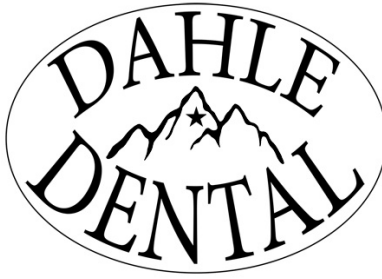
**X**

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient



**Authorization to Release Media**

Patient's Name: \_\_\_\_\_

Doctor's Name: Ryan Dahle, DMD and Dahle Dental

I hereby authorize Dahle Dental and Ryan Dahle, DMD or any of their assignees to take photographs, slides, and videos of my teeth, jaws, and face. I understand that the photographs, slides, videos, and comment cards will be used as a record of my care, and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. The content may also be used for advertising purposes (including website publication, facebook posts, etc).

I further understand that if the photographs, slides, and videos are used in any publication or as a part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs. If I wish to revoke this consent, I may do so in writing.

If declining this consent, leave blank.

Please initial one option:

I do not mind if my photographs are used in any of the above stated situations.

I only agree to have my teeth shown without any identifying features.

**X**

\_\_\_\_\_  
Patient / Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Relationship to Patient



**Consent for Use and Disclosure of Health Information**

**Section A: Patient Giving Consent**

Name: \_\_\_\_\_ Address: \_\_\_\_\_

**Section B: To the Patient – Please Read Carefully**

**Purpose of Consent:** By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

**Notice of Privacy practices:** You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices including any revisions of our Notice, at any time, by calling our office.

Phone 903-892-1052

**Right to Revoke:** You will have the right to revoke this Consent at any time by giving us written notice of your revocation. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

**Section C: Acknowledgement of Receipt of HIPAA Policies and Procedures**

I, \_\_\_\_\_, have been given the opportunity to review and request a copy of this Consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to you use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

**X**

\_\_\_\_\_  
Patient / Guardian Signature Date

**Section D: Additional People to Have Access to Information**

I would like to give the following persons access to my personal health information

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_

**X**

\_\_\_\_\_  
Patient / Guardian Signature Date