PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ (FIRST / MI / LAST) DATE _____

ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

E-MAIL _____ CELL PHONE _____ HOME PHONE _____

SS#/SIN _____ BIRTHDATE _____

CHECK APPROPRIATE BOX: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

IF COLLEGE STUDENT, F.T. / P.T., NAME OF SCHOOL _____ CITY _____ STATE/PROV. _____

PATIENT'S OR PARENT'S/GUARDIAN'S EMPLOYER _____ WORK PHONE _____

BUSINESS ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

SPOUSE OR PARENT'S/GUARDIAN'S NAME _____ EMPLOYER _____ WORK PHONE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____

ADDRESS _____ HOME PHONE _____

DRIVER'S LICENSE # _____ BIRTHDATE _____ SS#/SIN _____

EMPLOYER _____ WORK PHONE _____

IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ YES ☐ NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SS#/SIN _____ DATE EMPLOYED _____

NAME OF EMPLOYER _____ UNION OR LOCAL # _____ WORK PHONE _____

EMPLOYER ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

INSURANCE CO. _____ TEL. # _____ GRP # _____ POLICY / I.D. # _____

INS. CO. ADDRESS _____ CITY _____ STATE/PROV. _____ ZIP/P.C. _____

HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

X _____ _____

SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR PATIENT NUMBER

PATIENT MEDICAL HISTORY

PATIENT NAME: _____ DATE OF BIRTH: _____

ALTHOUGH DENTAL PERSONNEL PRIMARILY TREAT THE AREA IN AND AROUND YOUR MOUTH, YOUR MOUTH IS A PART OF YOUR ENTIRE BODY. HEALTH PROBLEMS THAT YOU MAY HAVE, OR MEDICATION THAT YOU MAY BE TAKING, COULD HAVE AN IMPORTANT INTERRELATIONSHIP WITH THE DENTISTRY THAT YOU WILL BE RECEIVING. THANK YOU FOR ANSWERING THE FOLLOWING QUESTIONS.

	Yes	No
ARE YOU IN GOOD HEALTH	☐	☐
HAVE THERE BEEN ANY CHANGES IN YOUR GENERAL HEALTH WITHIN THE PAST YEAR	☐	☐
DATE OF YOUR LAST PHYSICAL EXAM _____		
PHYSICIAN'S NAME _____		
ADDRESS _____		
PHONE NO _____		
ARE YOU NOW UNDER THE CARE OF A PHYSICIAN	☐	☐
HAVE YOU EVER BEEN HOSPITALIZED FOR ANY SURGICAL OPERATION OR SERIOUS ILLNESS	☐	☐
PLEASE EXPLAIN _____		
ARE YOU TAKING ANY MEDICINE(S) INCLUDING NON-PRESCRIPTION MEDICINE	☐	☐
IF YES, WHAT MEDICINE(S) ARE YOU TAKING _____ _____		
HAVE YOU HAD ANY ABNORMAL BLEEDING	☐	☐
DO YOU BRUISE EASILY	☐	☐

	Yes	No
HAVE YOU EVER REQUIRED A BLOOD TRANFUSION?	☐	☐
HAVE YOU HAD A RECENT WEIGHT LOSS	☐	☐
HAVE YOU EVER TAKEN FEN-PHEN/REDUX	☐	☐
DO YOU USE TABACCO	☐	☐
DO YOU OR HAVE YOU USED CONTROLLED SUBSTANCES	☐	☐
ARE YOU WEARING CONTACT LENSES	☐	☐
DO YOU HAVE A PERSISTENT COUGH OR THROAT CLEARING NOT ASSOCIATED WITH A KNOWN ILLNESS (LASTING MORE THAN 3 WEEKS)	☐	☐
DO YOU HAVE ANY DISEASE CONDITION OR PROBLEM NO LISTED ABOVE THAT YOU THINK I SHOULD KNOW ABOUT	☐	☐
WOMEN ONLY:		
ARE YOU PREGNANT OR THINK YOU MAY BE PREGNANT	☐	☐
ARE YOU NURSING	☐	☐
ARE YOU TAKING BIRTH CONTROL PILLS	☐	☐

ARE YOU ALLERGIC TO OR HAVE HAD REACTIONS TO:	Yes	No
LOCAL ANESTHETICS LIKE NOVACAINE	☐	☐
PENICILLIN OR OTHER ANTIBIOTICS	☐	☐
SULFA DRUGS	☐	☐
BARBITUATES, SEDATIVE OR SLEEPING PILLS	☐	☐
ASPIRIN	☐	☐
IODINE	☐	☐
ANY METALS (E.G. NICKEL, MERCURY, ETC.)	☐	☐
LATEX/RUBBER	☐	☐
OTHER (PLEASE LIST) _____		

	Yes	No
HIVE OR SKIN RASH	☐	☐
FAINTING OR DIZZY SPELLS	☐	☐
DIABETES OR PRE-DIABETES	☐	☐
AIDS OR HIV INFECTION	☐	☐
THYROID PROBLEMS	☐	☐
ALLERGIES	☐	☐
ARTHRITIS OR RHEUMATISM	☐	☐
JOINT REPLACEMENT OR IMPLANT	☐	☐
STOMACH ULCER	☐	☐
KIDNEY TROUBLE	☐	☐

DO YOU HAVE, HAVE YOU EVER HAD, OR ARE YOU BEING MONITORED FOR ANY OF THE FOLLOWING:

RHEUMATIC HEART DISEASE OR RHEUMATIC FEVER	☐	☐
SCARLET FEVER	☐	☐
HEART DEFECT OR MURMUR	☐	☐
HEART TROUBLE, HEART ATTACK, OR ANGINA	☐	☐
CHEST PAIN	☐	☐
SHORTNESS OF BREATH	☐	☐
PACEMAKER	☐	☐
HEART SURGERY	☐	☐
HIGH/LOW BLOOD PRESSURE	☐	☐
CONGENITAL HEART PROBLEM	☐	☐
SWELLING OF FEET, ANKLES, HANDS	☐	☐
HEPATITIS, JAUNDICE OR LIVER DISEASE	☐	☐
STROKE	☐	☐
SINUS TROUBLE	☐	☐
LUNG OR BREATHING PROBLEMS	☐	☐
ASTHMA OR HAY FEVER	☐	☐
COLD SORES	☐	☐
EATING DISORDERS	☐	☐
OSTEOPOROSIS OR BONE DENSITY	☐	☐
UNEXPECTED WEIGHT LOSS	☐	☐
ACID REFLUX OR GERD	☐	☐

TUBERCULOSIS	☐	☐
PERSISTENT COUGH	☐	☐
COUGH THAT PRODUCES BLOOD	☐	☐
CHEMOTHERAPY	☐	☐
SEXUALLY TRANSMITTED DISEASE	☐	☐
EPILEPSY OR SEIZURES	☐	☐
ANEMIA	☐	☐
GLAUCOMA	☐	☐
NERVOUSNESS	☐	☐
TONSILLITIS	☐	☐
TUMORS	☐	☐
MENTAL HEALTH CARE	☐	☐
BACK PROBLEMS	☐	☐
CHEMICAL DEPENDENCY	☐	☐
MITRAL VALVE PROLAPSE	☐	☐
CORTISONE TREATMENT	☐	☐
COLD SORES	☐	☐
HYPOGLYCEMIA	☐	☐
KNEE REPLACEMENT	☐	☐
EXCESSIVE THIRST	☐	☐

PATIENT NUMBER: _____

ATIENT DENTAL HISTORY

TIENT'S NAME _____ DATE OF BIRTH _____

EASON FOR THIS VISIT _____

'HEN WAS YOUR LAST DENTAL VISIT _____ WHAT WAS DONE THEN _____

OW OFTEN DID YOU VISIT THE DENTIST BEFORE THEN _____

REVIOUS DENTIST (NAME AND LOCATION) _____

AVE YOU HAD A COMPLETE SERIES OF DENTAL FILMS (X-RAYS) TAKEN WHEN WHERE _____

OW OFTEN DO YOU BRUSH YOUR TEETH _____ HOW OFTEN DO YOU FLOSS YOUR TEETH _____

S YOUR DRINKING WATER FLUORIDATED _____

	YES	NO
)O YOUR GUMS BLEED WHILE BRUSHING OR FLOSSING	☐	☐
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS	☐	☐
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS	☐	☐
)O YOU FEEL PAIN TO ANY OF YOUR TEETH	☐	☐
)O YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH	☐	☐
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES	☐	☐
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOUR JAW?		
CLICKING	☐	☐
PAIN (JOINT, EAR, SIDE OF FACE)	☐	☐
DIFFICULTY IN OPENING OR CLOSING	☐	☐
DIFFICULTY IN CHEWING	☐	☐
DO YOU HAVE FREQUENT HEADACHES	☐	☐
DO YOU CLENCH OR GRIND YOUR TEETH	☐	☐

	YES	NO
DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY	☐	☐
HAVE YOU NOTICED ANY LOOSENING OF YOUR TEETH	☐	☐
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH	☐	☐
HAVE YOU EVER HAD PERIODONTAL TREATMENT (GUMS)	☐	☐
EVER WORN A BITE PLATE OR OTHER APPLIANCE	☐	☐
HAVE YOU EVER HAD ANY DIFFICULT EXTRACTIONS IN THE PAST	☐	☐
HAVE YOU EVER HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS	☐	☐
DO YOU WEAR DENTURES OR PARTIALS	☐	☐
IF YES, DATE OF PLACEMENT _____		
HAVE YOU EVER RECEIVED ORAL HYGIENE INSTRUCTIONS REGARDING THE CARE OF YOUR TEETH AND GUMS	☐	☐

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

AUTHORIZATION AND RELEASE

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION TO THE BEST OF MY KNOWLEDGE. THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED. I UNDERSTAND THAT PROVIDING INCORRECT INFORMATION CAN BE DANGEROUS TO MY HEALTH. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME OR MY CHILD DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST OR DENTAL GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY DENTAL INSURANCE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS.

X _____ DATE _____
SIGNATURE OF PATIENT OR PARENT/GUARDIAN IF MINOR

DOCTOR'S COMMENTS _____

SIGNATURE _____ DATE _____

PATIENT NUMBER

ACKNOWLEDGEMENT OF PRIVACY NOTICE RECEIPT

I have been made aware of the HIPAA PRIVACY PRACTICE NOTICE for Drs. Norman Mason and O.W.McElveen's dental office at 7408 Cameron Road Suite A, Austin Tx 78752, which is posted in the reception room and I was given the opportunity to read a copy which went in effect April 14, 2004.

PRINT NAME OF PATIENT

SIGNATURE OF INDIVIDUAL OR REPRESENTATIVE / RELATIONSHIP TO PATIENT/ DATE

FINANCIAL RESPONSIBILITY

I authorize release of any dental or other information necessary to process insurance claims. I also request payment benefits to be made to Drs. Mason and McElveen. Insurance claims, while we do our best to determine your out of pocket expense at the time of service, we cannot be certain until your insurer pays your claim. At that time, we will bill you for any unpaid balance or refund any overpayment.

Signature of patient or representative

Patient authorization

I hereby authorize the office of Drs. Mason and McElveen to use, disclose or request specific information described below, only for the purpose and parties also described below.

Name Date

Relationship to patient

UNDERSTANDING YOUR PPO INSURANCE

Your GROUP INSURANCE POLICY (**PREFERRED PROVIDER OFFICE**) is a contract between you (employee) and your insurance carrier.

Your **PPO GROUP POLICY** represents a negotiated agreement between your employer and your Insurance Company that establishes the conditions and extent of your company's coverage benefits.

Our office (**MM DENTISTRY**) **HAS CONTRACTED WITH YOUR Insurance Carrier** as a **PPO** in order to provide "those dental services" that are covered by your Insurance Plan at a highly discounted fee (35% -40%).

Each Company/ Employer's **PPO** Dental Plan is specifically negotiated and contains a complex system of coverage that includes certain limitations, exclusions, exceptions and conditions that is defined only in your **"INSURANCE POLICY BOOKLET".**

MM DENTISTRY has NO control over what procedures your insurance will cover or pay!!
For the most accurate estimate of your insurance benefits, please provide our office with your current **"INSURANCE POLICY BOOKLET)**

A FEE OF $25.00 WILL BE CHARGED FOR APPOINTMENT CANCELLATION OF LESS THAN 24 HOURS NOTICE.

I have read and understand the above statement.

_____DATE_____

MEDICATION LOG

Name :
Date of Birth :
Address :
:

Doctor :
Doctor Phone # :
Pharmacy :
Pharmacy Phone # :

Medication	Dosage	Date	Time	Remark

WMM

Mason-McElveen Family Dentistry

7408 Cameron Rd Suite A

Austin, Texas 78752

512-4779775

Smile Evaluation

- Are you happy with the appearance of your teeth/gums/smile?

  Yes No

- Would you like to discuss enhancing the appearance of your smile?

  Yes No

- What don't you like about your smile?

_____

_____

- Would you like to discuss how to make your teeth WHITE?

  Yes No

_____