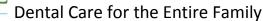


PATIENT INFORMATION





6449 Coit Rd. Suite 104, Frisco, TX 75035 - (214)436-4600

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Date Hor	ne Phone	Cell Phone					
Name							
Last Name	First nan	me					
Address		E-mail					
City	State	Zip					
Sex Age Birthd	ate	☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered foryears					
		occupation					
Employer/School Address		Employer Phone					
How did you hear about us?Yellow pages AdsMail coupon SignFriend/RelativeOther							
In case of emergency who should be notified? ————		Phone ————					
PRIMARY INSURANCE							
Person Responsible for Account (Last Name)		(First Name) (Middle Initial)					
Relation to Patient	Birthdat	eID#/SSN					
Address (if different from Patient's)		Phone					
City	State	Zip					
Person Responsible Employed by		Occupation					
Business Address	Business Phone						
Insurance Company							
Contract #	Group#	Subscribe#					
Name of other dependents cover under this plan							
ADDITIONAL INSURANCE							
Is patient covered by additional insurance?	Yes	No					
Subscriber Name		Relation to Patient Birthdate					
Address (if different from Patient's)		Phone					
City	State	Zip					
Subscriber Employed by		Occupation					
Business Address		Business Phone					
Insurance Company		SSN#					
Contract#		Group# Subscribe#					
Name of other dependents covered under this plan							

DENTAL HISTORY Reason for Today's Visit _____ Date of last dental Care _____ Former Dentist Date of last dental X-Rays Address _ Check if you have had problems with any of the followings: Sensitivity to hot Bad breath Grinding teeth Bleeding gums Clicking or popping jaw Food collection between teeth Close teeth or broken fillings Sensitivity to sweets Sensitivity when biting Sores or growths in your mouth How often do you floss? How often do you brush? MEDICAL HISTORY Physician's Name______ Date of Last Visit _____ Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" these include combinations of Ionimin, Adipex, Fastin (brand names of Phentermine), Pondimin (fenfluramin) and Redux (dexfenfluramine). ____ Yes ___ NO Have you had any serious illnesses or operations? Have you ever had a blood transfusion? Yes No (WOMEN) Are you pregnant? Yes No Nursing? Yes No Taking Birth control Pills? — Yes — No Check if you have had problems with any of the followings: Anemia Cortisone Treatments Scarlet fever Hepatitis Arthritis, Rheumatism Artificial Heart Valves 0 Cough, Persistent Shortness of Breath High Blood Pressure Cough, Blood 0 Skin Rash HIV/AIDS 0 Artificial Joints Diabetes Stroke Jaw Pain Epilepsy Fainting Glaucoma Headaches Heart murmur Heart Problems Hemophilia Asthma 0 O Swelling of Feet or Ankles Kidney Disease Back Problems Blood Disease Cancer 0 Thyroid Problems Liver Disease 0 Tobacco Habit Mitral Valve Prolapse 0 Tonsillitis Pacemaker Chemical Dependency 0 Radiation Treatment Tuberculosis Chemotherapy Cardiac problems 0 Respiratory Disease Ulcer Rheumatic Fever Venereal Disease MEDICATIONS Other List Medications you are Currently Taking: ALLERGIES Aspirin Local Anesthetic Codeine Penicillin o lodine Sulfa Latex o Other _____ Barbiturates Pharmacy Name — Phone — Phone — (Sleeping Pills) AUTHORIZATION I certify that I, and/or my dependents(s) have insurance coverage with ______ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-name dentist may use my health care information and may disclose such information to the above-name insurance company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable to related service. This consent will end when my current treatment plan is completed or one year from the date signed below.

Relationship to Patient

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative



Financial Policy

THANK YOU for choosing us as your dental care provider. Our greatest concern is your complete oral health. Anything we do or say will be centered on that philosophy. It is suggested that each patient be seen every six months (or as needed) to ensure this preventive philosophy is met. We are committed to your treatment being successful, and to the return and maintenance of your good health. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our FINANCIAL POLICY, which we ask you to read and sign prior to any treatment.

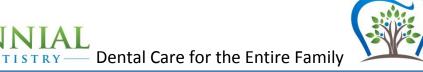
PAYMENT FOR SERVICS RENDERED: Patients are responsible for payment of all services rendered on their behalf or their dependents. Payment is due at the time of service unless other financial arrangements have been made in writing in advance.

INSURANCE ASSIGNMENTS: We may accept assignments of insurance benefits; however, most insurance plans do not cover 100% of the fees charged and have a deductible, which must be satisfied before any insurance benefits can be received. Also, keep in mind that some, and perhaps all, of the services are not considered reasonable and necessary under the provisions of your insurance plan. If our office accepts your insurance company's assignment, it does not absolve the patient's responsibility for charges in full for the treatment rendered. We require that all deductibles, co-pays, and/ or any percentage of the bill that the primary insurance carrier does not cover, be paid at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that company's assignment. If your insurance company has not paid your balance in full within 60 days, the balance will automatically be transferred to your account, and you will be responsible for the balance owed. This office cannot render services on the assumption that our fees will be paid by your insurance company.

INSURANCE FACTS: Some insurance companies set their fee schedule unrealistically low to limit the amount they must pay in benefit. This does not mean that our fees are too high. We set our fees according to a national dental fee survey. Most insurance companies have a yearly deductible. You will need to know what your deductible is and pay that amount before you insurance company will begin to pay benefits.

DEFAULT ON PAYMENT: In the event of default on payment, the patient (guardian) promises to pay any and all collection costs and attorney fees as may be required to effect collection of this account.

Patient(s)	 	
Responsible Party Signature		
(Parent/Guardian if Patient is a minor)		



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

		CONSERT	_
			_
Home Phone:		Work Phone:	
Social Security:		E-Mail:	
SECTION B: TO	THE PATIENT – F	PLEASE READ THE FOLLOWING STATEMENTS O	CAREFULLY
		rm, you will consent to our use and disclosure of your protes, and healthcare operations.	ected health informatio
this consent. Our and disclosures w	Notice provides a desc e may make of your p n. A copy of our Notic	e the right to read our Notice of Privacy Practice before you cription of our treatment, payment activities, and healthcare protected health information, and of other important matter ce accompanies the Consent. We encourage you to read it consents the consents of the protection of	e operations, of the uses about your protected
privacy practices,	we will issue a revise	acy practices as described in our Notice of Privacy Practice d Notice of Privacy Practices, which will contain the chang formation that we maintain.	
You may obtain a contacting.	copy of our Notice of	f Privacy Practices, Including any revisions of our Notice, a	at any time by
Contact Person: Telephone: E-mail: Address:	info@centennialfam	Fax: (214)436-4613 hilydentistryfrisco.com e 104, Frisco, TX, 75035	
revocation submit action we took in	ted to Contact Person	ght to revoke this Consent at any time by giving us written a listed above. Please understand that revocation of this Conent before we received your revocation, and that we may deconsent.	sent will not affect any
SIGNATURE			
I, and the Notice of disclose my protection	Privacy Practices. I uncted health information	have had full opportunity to read and consider the contents inderstand that, by signing this consent form, I am giving m on to carry out treatment activities and health care operation	s of this Consent from y consent to use and us.
Signature:		Date:	_
		representative on behalf of the patient, complete the following	
Personal Representa	ntive's Name:		<u> </u>