CENTENNIAL
FAMILY DENTISTRY
Dental Care for the Entire Family

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.

PATIENT INFORMATION

Date _____ Home Phone _____ Cell Phone _____

Name _____ SSN/Patient ID# _____
Last Name First name

Address _____ E-mail _____

City _____ State _____ Zip _____

Sex _____ Age _____ Birthdate _____ ☐ Married ☐ Widowed ☐ Single ☐ Minor ☐ Separated ☐ Divorced ☐ Partnered for____years

Patient Employer/School _____ occupation _____

Employer/School Address _____ Employer Phone _____

How did you hear about us? ☐ Yellow pages ☐ Ads ☐ Mail coupon ☐ Sign ☐ Friend/Relative ☐ Other

In case of emergency who should be notified? _____ Phone _____

PRIMARY INSURANCE

Person Responsible for Account (Last Name) _____ (First Name) _____ (Middle Initial) _____

Relation to Patient _____ Birthdate _____ ID#/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:

- ○ Bad breath
- ○ Bleeding gums
- ○ Clicking or popping jaw
- ○ Food collection between teeth
- ○ Grinding teeth
- ○ Periodontal treatment
- ○ Sensitivity to cold
- ○ Loose teeth or broken fillings
- ○ Sensitivity to hot
- ○ 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? ☐ Yes ☐ No

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
- ○ Arthritis, Rheumatism
- ○ Artificial Heart Valves
- ○ Artificial Joints
- ○ Asthma
- ○ Back Problems
- ○ Blood Disease
- ○ Cancer
- ○ Chemical Dependency
- ○ Chemotherapy
- ○ Cardiac problems
- ○ Cortisone Treatments
- ○ Cough, Persistent
- ○ Cough, Blood
- ○ Diabetes
- ○ Epilepsy
- ○ Fainting
- ○ Glaucoma
- ○ Headaches
- ○ Heart murmur
- ○ Heart Problems
- ○ Hemophilia
- ○ Hepatitis
- ○ High Blood Pressure
- ○ HIV/AIDS
- ○ Jaw Pain
- ○ Kidney Disease
- ○ Liver Disease
- ○ Mitral Valve Prolapse
- ○ Pacemaker
- ○ Radiation Treatment
- ○ Respiratory Disease
- ○ Rheumatic Fever
- ○ Scarlet fever
- ○ Shortness of Breath
- ○ Skin Rash
- ○ Stroke
- ○ Swelling of Feet or Ankles
- ○ Thyroid Problems
- ○ Tobacco Habit
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Ulcer
- ○ Venereal Disease
- ○ Other

MEDICATIONS

List Medications you are Currently Taking:

_____

_____

_____

ALLERGIES

- ○ Aspirin
- ○ Codeine
- ○ Iodine
- ○ Latex
- ○ Barbiturates (Sleeping Pills)
- ○ Local Anesthetic
- ○ Penicillin
- ○ Sulfa
- ○ Other _____

Pharmacy Name _____ Phone _____

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.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____

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

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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)

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____

Social Security: _____ E-Mail: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS 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 Practice 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 matter about your protected health information. A copy of our Notice accompanies the 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 contacting.

Contact Person: Aparna Angadi
Telephone: (214)436-4600 Fax: (214)436-4613
E-mail: info@centennialfamilydentistryfrisco.com
Address: 6449 Coit Rd., Suite 104, Frisco, TX, 75035

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Contact Person listed above. 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.

SIGNATURE

I, _____ , have had full opportunity to read and consider the contents of this Consent from and the Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to use and disclose my protected health information to carry out treatment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____