651 N. U.S. HWY 183, STE 150
LEANDER, TX 78641
512-260-0123

Welcome and thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely.

PATIENT INFORMATION (CONFIDENTIAL)

Full Name: _____ Preferred Name:_____
Street Address: _____City: _____
State & Zip: _____Age: _____Sex: (MALE/ FEMALE) Birth Date: _____ Marital Status: _____
Home Phone: _____Work Phone: _____Mobile/Pager #: _____
E-mail: _____Social Security #: _____

Insurance Coverage:
Insured Name:_____Insurance Company:_____
_____

Spouse/Parent INFORMATION - *Please fill out completely. (Fill in Parent Information if patient is a Minor)*

Wife/Mother	Husband/Father
Name:	Name:
Work Phone, Mobile Phone:	Work Phone, Mobile Phone:

Whom may we thank for referring you? _____
Reason for your visit today? _____
Previous Dentist: _____ Date of Last Dental Visit: _____

PATIENT DENTAL HISTORY

Do you require antibiotics before dental treatment? Y/N	Do your gums ever bleed? Y/N
Are you currently in pain? Y/N	Have you ever had periodontal disease? Y/N
Have you ever had a serious / difficult problem associated with any previous dental work? Y/N	How many times a week do you brush? _____ A day do you Floss? _____
Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)? Y/N	Type of bristles? Hard / Medium / Soft

HEALTH INFORMATION

Medical Physician: _____ Office Phone _____ Last Visit _____

Are you under medical care now? (If so, please describe)

_____

_____

_____Please list any medications you are taking (including non prescription)

_____

_____

_____Are You Pregnant? (YES / NO) Due Date: _____ **(Please inform us if you become pregnant.) Please inform us if your health information should change in any way**.

Yes	No		Yes	No	
		Anemia / Radiation Treatment			**Hemophilia / Abnormal Bleeding**
		Artificial Bones/ Joints/ Valves			**Hepatitis**
		Arthritis			**High / Low Blood Pressure**
		Asthma			**HIV + / AIDS**
		Blood Transfusion			**Hospitalized for Any Reason**
		Cancer / Chemotherapy			**Kidney Problems**
		Congenital Heart Defect			**Mitral Valve Prolapse**
		Diabetes			**Psychiatric Problems**
		Respitory Problems			**Rheumatic / Scarlet Fever**
		Drug / Alcohol Abuse			**Severe / Frequent Headaches**
		Liver Disease			**Shingles**
		Epilepsy / Seizures / Fainting Spells			**Sickle Cell Disease / Traits**
		Fever Blisters / Herpes			**Sinus Problems**
		Heart Attack / Stroke			**Tuberculosis (TB)**
		Heart Murmur			**Ulcers / Colitis**
		Heart Surgery / Pacemaker			**Venereal Disease**
		Tobacco Use			

Allergies (please place an "X" in the Yes / No boxes)

Yes	No		Yes	No	
		Penicillin			**Iodine**
		Local Anesthetics			**Latex/Rubber**
		Aspirin			**Sulfa Drugs**
		Codeine			

Please list any other allergies:_____

_____

Is there any other health information we should know?_____

_____

Whom should we contact in case of an emergency? **(Please do not leave this blank)**

Name:_____**Phone:**_____**Relationship:**_____

HIPPAA NOTICE OF PRIVACY PRACTICES

OUR LEGAL DUTY:

Our office is required by law to maintain the privacy of your health information, to give you notice about how we do this and what your rights are.

HOW WE USE YOUR HEALTH INFORMATION:

We use your health information for treatment, payment and healthcare operations. This means- We may discuss your health information with another doctor or healthcare worker involved in your treatment. We may use this information to obtain payment for your treatment from third parties such as insurance companies. We may also use this information for our internal operations such as training and quality assessment and to contact you about appointments using phone, mail or email. You have the right to decide who else, by specific signed authorization, has access to your health information such as family members, employers, marketing companies or other entities not directly related to our office or your treatment. We must disclose your health information when required to do so by law or if we believe your health or safety or the health or safety of other is threatened.

YOUR RIGHTS:

You may request, in writing, a copy of your health information. We may charge a reasonable fee for this service. Upon request, a more detailed and lengthy explanation of our policies is available. Questions and Complaints-If you have any issues concerning the privacy of your health information, you may direct your complaints to the contact person listed below. You may also submit a written complaint to the US Dept. of Health and Human Services. Contact Officer: Robert Hogge, D.D.S. (512)260-0123. 651 N. U.S. Hwy 183, Ste 150, Leander, TX 78641.

Thank you for helping our office complies with federal law on health information privacy policies

There is a returned check fee of $55.00 plus the amount of the check.
ACCOUNT BALANCES NOT PAID WILL BE TURNED OVER TO A COLLECTION AGENCY and COLLECTION FEES WILL BE ADDED TO YOUR ACCOUNT.
*****PAYMENT IS DUE PRIOR TO DENTAL TREATMENT******