DENTISTRY YOU CAN TRUST FROM A DENTIST WHO CARES.

Rowlett Smiles

by Mark W. Boren, DDS

972-463-1001

www.rowlettsmiles.com

7100 Rowlett Road, Rowlett, TX 75089

PATIENT INFORMATION

Date_____ DL#_____ SS# _____

Patient Name _____
Last Name

_____
First Name Middle Initial "Preferred"

Address _____

City _____

State_____ Zip_____

Phone #s: Home_____Work_____Cell _____

E-mail_____

Sex ☐ M ☐ F Age_____ Birthdate_____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced

Patient Employer/School _____

Occupation/Hobby _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer_____

Whom may we thank for referring you?_____

INSURANCE INFORMATION

Who is responsible for this account? _____

Relationship to Patient_____

Insurance Co. _____

Group #_____Phone # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS# _____

Relationship to Patient_____

Insurance Co. _____

Group #_____Phone # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____and assign directly to
Name of Insurance Company(ies)

Dr._____all insurance benefits, if any, otherwise payable to me for services 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-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. 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

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

_____ _____
Date Relationship to Patient

Rowlett Smiles is a participating provider for Delta, Guardian, Assurant/DHA, Aetna, DeCare & Metlife dental PPO plans. If your insurance is with any other carrier, you may be "out of network" for your dental benefits. Any conflict or dispute over benefit coverage & fee schedules are between you & your insurance carrier. You will be responsible for any remaining balance. _____ initial

DENTAL INFORMATION

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Are you happy with your smile	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw/jaw pain	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Food collection between teeth	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold/heat/sweets	☐ Yes	☐ No
Sensitivity to biting	☐ Yes	☐ No
Would you like your teeth to be whiter	☐ Yes	☐ No

How often do you floss?_____

- OVER -

HEALTH HISTORY

Physician's Name\Phone # _____ 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 (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Emphysema/Breathing or Lung Problems	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Heart Murmur/MVP	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Heart Problems_____	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Chemotherapy/Radiation	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No		

Have you ever taken osteoporosis medicines such as Fosamax? ☐ Yes ☐ No

Have you ever been told you need to take an antibiotic premed before any dental visit? ☐ Yes ☐ No

Do you have any other medical concerns? _____

Women:

Are you pregnant? ☐ Yes ☐ No Due date _____ Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

_____

_____

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin	☐ Local Anesthetic
☐ Barbiturates (Sleeping pills)	☐ Penicillin
☐ Codeine	☐ Sulfa
☐ Iodine	☐ Other _____
☐ Latex	_____

IN CASE OF EMERGENCY, CONTACT:

Name _____ Relationship _____ Phone # _____

I have received a copy of this office's Notice of Privacy Practices.

_____

Print Name Signature Date

I hereby release and give my consent for Rowlett Smiles to use my diagnostic photos and models to their discretion for marketing, educational or professional purposes and publications:

Signed _____ Date _____

- - - - - - FOR OFFICE USE ONLY - - - - - -

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

____ Individual refused to sign
____ Communications barriers prohibited obtaining the acknowledgement
____ An emergency situation prevented us from obtaining the acknowledgement
____ Other (Please Specify)

_____

INSURANCE & FINANCIAL RESPONSIBILITY AGREEMENT

At **Rowlett Smiles**, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know:

INITIAL:

- _____Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.
- _____I understand and agree it is **my responsibility** to know if my insurance has any deductibles, co-payments, age limits, exclusions, waiting periods, missing tooth clauses or any other type of benefit limitation for the services I receive and I agree to make full payment. Many times these exclusions are provided to employees only & are not made available to our staff when confirming benefits, they are your responsibility to know, we can only estimate based on what your insurance discloses to us.
- _____We currently accept all private care insurance plans. We are currently a contracted provider for only: Metlife, Guardian, Delta Dental Premier, Cigna, Assurant, Humana & Aetna insurance plans. This means that we work with literally thousands of companies. It is your responsibility to know if Rowlett Smiles is a contracted in-network provider recognized by your insurance plan. Although we can maintain a computerized history of payments by a given company, they do change; therefore it is impossible to give you a **guaranteed quote** at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. If you would like to know your insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. Keep in mind that this is still not a guarantee of coverage. This does delay treatment but will give you the best estimate of what your out of pocket figures will be.
- _____We will bill your insurance as a courtesy. If insurance does not pay within 90 days, Rowlett Smiles reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between **YOU and your insurance company**. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office. Any delinquency on your account will result in a $10/month late fee added to the account and finance charges at 18% annually will be applied. In the event that Rowlett Smiles incurs any expense in the collection of my account, expenses for collections agencies or court costs will be applied to my account.
- _____**Rowlett Smiles** does require payment in full for your estimated portion at the time of service. We accept MasterCard, Visa, American Express, Discover, cash and checks (for existing patients with established payment history). If you are in need of an extended finance option, we also work with Care Credit, CitiHealth & Chase Financial who offer 3, 6, or 12 month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit.
- _____A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we do require at **least 24 hour** notice to avoid a **$45/hour cancellation fee** (emergencies are an exception).

I agree with the above conditions. Date:_____

Patient/Parent Signature: _____ Print Name:_____