Date ____________________

MEDICAL HISTORY FORM

PATIENT INFORMATION

Patient's Name: ______________________________ (Last / First / Middle Initial)

Address: ______________________________ (Address / City / State / Zip Code)

Email Address: ____________ SSN: _____-_____-_____ Date of Birth: _____/_____/_____ Age: _____

Sex: ❑ M ❑ F Home No: (_____) __________ Alt. No: (_____) __________

PARENT/GUARDIAN INSURANCE INFORMATION

Relationship to Patient: ____________________ ❑ SELF

Name: ______________________________ (Last / First / Middle Initial)

SSN: _____-_____-_____ Insurance No.: __________ Driver License No.: __________

Date of Birth: _____/_____/_____ Insurance Telephone No.:(_____) __________ Group No.: __________

Employer: ____________________ Address: ____________________

Home No: (_____) __________ Alt. No: (_____) __________

Name and Number of nearest relative not living with you: ____________________

HOW DID YOU HEAR ABOUT US? PLEASE MARK BELOW

❑ Yellow Pages ❑ Friend / Relative ❑ Flyers / Mail ❑ Bill Board ❑ Insurance / Employer ❑ Internet __________

❑ Sign ❑ THMP-Medicaid ❑ Health Fairs / Screenings ❑ Employee ❑ Other (Specify) __________

Reason for today's dental visit: ____________________ Date of last dental visit: __________

MARK APPROPRIATE ANSWER (leave blank if you do not understand the question)

Yes	No	
❑	❑	Have you ever had an experience in a dental office that you would like to tell us about? *Please explain if yes:* __________
❑	❑	Are you nervous about dental treatment?
❑	❑	Do your gums bleed, feel tender or irritated?
❑	❑	Are you unhappy with appearance of your teeth?
❑	❑	Are your teeth sensitive? *If yes, to what?* ❑ Sweets ❑ Hot ❑ Cold ❑ Pressure
❑	❑	Do you have discolored teeth that bother you?
❑	❑	Are you now seeing a physician? *The name & telephone number of your physician(s)* __________ *If so, what is the condition being treated?* __________
❑	❑	Are you taking any medications? *If yes, please list:* __________
❑	❑	Have you or are you currently taking Aspirin?
❑	❑	If female, are you or do you suspect to be pregnant? No. Months: __________
❑	❑	Have you or are you currently taking oral Bisphosphates? ❑ Actonel ❑ Boniva ❑ Fosamax ❑ Skelif ❑ Didrone ❑ Other __________
❑	❑	Have you had any joint replacements? *If yes, when?* __________
❑	❑	Is there anything else we should know about your health that was not covered on this form? *If yes, Please explain:* __________

DO YOU HAVE OR HAVE YOU HAD

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Disease	❑	❑	Anemia	❑	❑	Nervousness	❑	❑	HIV or AIDS
❑	❑	Heart Murmur	❑	❑	Kidney Trouble	❑	❑	Thyroid Disease	❑	❑	Hepatitis
❑	❑	High Blood Pressure	❑	❑	Bone Loss	❑	❑	Chemo: (Cancer, Leukemia)	❑	❑	Hemophilia
❑	❑	Blood Disease	❑	❑	Epilepsy or Seizures	❑	❑	Arthritis	❑	❑	Sickle Cell Disease
❑	❑	Rheumatic Fever	❑	❑	Ulcers	❑	❑	Rheumatism	❑	❑	Bruise Easily
❑	❑	Venereal Disease	❑	❑	Emphysema	❑	❑	Cortisone Medicine	❑	❑	Pain in Jaw Joint
❑	❑	Heart Pacemaker	❑	❑	Tuberculosis	❑	❑	Joint Replacement	❑	❑	Diabetes
❑	❑	Asthma	❑	❑	Scarlet Fever	❑	❑	Hay Fever	❑	❑	Glaucoma

DO YOU HAVE ALLERGIES TO ANY OF THE FOLLOWING

❑	❑	Local Anesthetics	❑	❑	Penicillin	❑	❑	Codeine or other narcotics	❑	❑	Other antibiotic: __________
❑	❑	Aspirin	❑	❑	Fen-Phen	❑	❑	Barbiturates or sedatives	❑	❑	Other: __________
❑	❑	Iodine	❑	❑	Sulfa Drugs	❑	❑	Latex	❑	❑	Other: __________

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if any medicines change, I will inform my dentist at the next appointment.

____
Signature of Patient/Parent/Guardian

FOR COMPLETION BY DENTIST

Date	Comments	Signature of patient and dentist

Dental Risk Assessment Questionnaire

Parents and caregivers – use this form to tell us about the oral health of your child. This will be part of your child's health record.

Parent/Guardian Name ______________________ **Date** ______________

Child's Name ______________________ **Child's Age** ______________

	Yes	No
1. Does your family drink water with fluoride in it or do your children take fluoride tablets?	☐	☐
2. Does your child use a toothpaste with fluoride in it?	☐	☐
3. Do you help your child with toothbrushing?	☐	☐
4. Have you or your children ever had a bad dental experience?	☐	☐
5. Have any of your children ever had cavities?	☐	☐
6. Does your child complain of mouth pain?	☐	☐
7. Does your child take a bottle to bed?	☐	☐
8. Does your child walk around drinking from a bottle or cup?	☐	☐

9. How many times does your child eat a snack each day? __________

10. How many bottles does your child have each day? __________

11. How is your own dental health? ☐ Good ☐ Fair ☐ Poor

12. Do you have any cavities?	☐	☐
13. Do your gums bleed?	☐	☐

Did you know?

For every 100 school children, more than 5 days of school per year are lost due to dental disease.

Good dental health is important!

PRIVACY NOTIFICATION: With few exceptions, you have the right to request and be informed about information that the State of Texas collects about you. You are entitled to receive and review the information upon request. You also have the right to ask the state agency to correct any information that is determined to be incorrect. See **http://www.dshs.state.tx.us** for more information on Privacy Notification. (Reference: Government Code, Section 552.021, 552.023, 559.003 and 559.004)

TEXAS Department of State Health Services
EF08-12879 Rev-0208

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

SUMMARY:

By law we are required to provide you with our Notice of Privacy Practices (NPP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to report of disclosures of your information; and
6. The right to a paper copy of this Notice.

We want to assure you that your medical/protected health information is secure with us. This Notice of Privacy Practice contains information about how we will insure that your information remains private.

Please list all telephone numbers where we may contact you:

____

____

PLEASE LIST THE NAMES OF ALL PEOPLE (e.g. SPOUSE, PARENTS, GRANDPARENTS, ETC...) YOU AUTHORIZEUS TO RELEASE YOUR HELATH INFORMATION TO, INCLUDING COPIES OF YOUR RECORDS IF NEEDED:

____

____

Acknowledgement of Notice of Privacy Practice

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practice. I further understand that the practice will offer me updated to this Notice of Privacy Practice. Should it be amended, modified or changed in any way I will receive a copy.

____

Printed Name of Patient

____

Signature of Patient/Parent/Guardian

FOR OFFICE USE ONLY

☐Patient refused to sign

☐Patient was unable to sign because: ________________________

Date: ________ Signature: ____________________

Oral Health Questionnaire

Child's Name ______________________________ **Date** ______________

Child's Age ____________________ **Child's Date of Birth** ______________

HEALTH HISTORY	**Yes**	**No**
Did the birth mother have any problems during pregnancy?	☐	☐
Was your child premature?	☐	☐
Was your child's birth weight low?	☐	☐
Were there any complications at birth?	☐	☐
Has your child been ill?	☐	☐
Is your child on any medications?	☐	☐
DIET AND NUTRITION		
Is/was your child breastfed?	☐	☐
Does your child sleep with a bottle?	☐	☐
Does your child drink from a cup?	☐	☐
Does your child walk around drinking from a bottle or cup?	☐	☐
Is your child on a special diet?	☐	☐
How many times does your child snack each day? ________		
How many bottles does your child have each day? ________		
FLUORIDE ADEQUACY		
Do you know the fluoride level of your water?	☐	☐
Do you have well water?	☐	☐
Do you use bottled water?	☐	☐
Do you use a water conditioner or filtration system?	☐	☐
If yes, please list ______________________		
Do you use fluoride toothpaste for your child?	☐	☐
ORAL HABITS		
Does your child use a pacifier?	☐	☐
Does your child suck a thumb or fingers?	☐	☐
Does your child grind his/her teeth day or night?	☐	☐
INJURY PREVENTION		
Is your child walking?	☐	☐
Is your home childproofed?	☐	☐
Do you use a car seat for your child?	☐	☐
Has your child had an injury to his/her mouth or face?	☐	☐
ORAL DEVELOPMENT		
Does your child have any teeth?	☐	☐
Child's age (in months) when the first tooth came in? _______		
Has your child had teething problems?	☐	☐
Have you noticed any problems with your child's mouth or teeth?	☐	☐
Does your child complain of mouth pain?	☐	☐
Have any of your children ever had cavities?	☐	☐
Have you or your children ever had a bad dental experience?	☐	☐
ORAL HYGIENE		
Do you clean your child's gums/teeth?	☐	☐
Do you use a toothbrush to clean your child's teeth?	☐	☐
Do you use toothpaste to clean your child's teeth?	☐	☐

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1013 W University Ave Suite 345
Georgetown, TX 78628
Phone 512-869-4850 Fax 512-869-8485

Non-parental consent to dental care and treatment

I, _________________________________, parent/legal guardian of the child(ren) listed below do herby give authorization and consent for the authorized person(s) reflected below to authorize the dental services provided to my child(ren), as well as any dental care and treatment deemed necessary for the well-being of my child(ren).

I am, by this document, representing that I have authority to consent for all dental care and treatment of said child(ren):

______________________ ________________________ ____________
Signature Relationship to child(ren) Date

Child(ren):

_____________________________ ____________________________
Name Name

_____________________________ _____________________________
Name Name

Authorized person(s):

_____________________________ ______________________________
Name Relationship to Parent or Guardian

IDENTIFICATION MUST BE ON FILE FOR AUTHORIZED PERSON(S)

________________________________ ________________________
Signature of Parent/Legal Guardian Date

____
Appointment Date

L E G E N D D E N T A L
1 0 1 3 W . U N I V E R S I T Y A V E
S U I T E 3 4 5
A U S T I N , T X 7 8 7 4 5

T E L : (5 1 2) 8 6 9 - 4 8 5 0 F A X : (5 1 2) 8 6 9 - 8 4 8 5

Courtesy insurance billing information

We are happy to file your insurance claims for you, and will help you with coordination of benefits. In order for us to bill your insurance company you will need to provide us with a copy of an insurance card or billing address for them. As a courtesy to you, we verify your dental benefits. *However, it is your responsibility to verify your own benefits with your insurance company, as you are ultimately responsible for your bill.*

If you have a percentage co-insurance payment, please be aware that the amount you are paying at each visit is **only an estimate**. We do not know the exact amount of you co-insurance payment until we receive payment from you insurance company. You may receive an additional bill from us after we have received payment from your insurance company.

You may become responsible for your bill if:

- Claim is returned based on the information you or your insurance company provided us.
- Our office provides composite fillings (white) and some insurance companies down-grade to amalgam fillings (silver) rates. You will be responsible for the difference in cost.
- You are not sure which insurance company has primary responsibility for payment.
- You do not inform us promptly (within 24 hours of service) of changes to your insurance plan.
- Your eligibility or pre-authorization for services has expired and you elect to continue treatment.
- Your insurance company determines that in their opinion treatment was not necessary.
- An authorization is revoked by your insurance.
- If your insurance policy has waiting periods under your plan for basic or major treatment procedures.

Patient’s Name: ____________________________

Patient/Legal guardian signature: ____________________ Date: _____________