TEXAS DENTAL SOLUTIONS
SPECIALTY PROSTHODONTICS IN DALLAS AND FLOWER MOUND

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MAXILLOFACIAL PROSTHODONTIST

PATIENT INFORMATION

TODAY'S DATE: _____

☐ M r . ☐ Mrs. ☐ Ms. ☐ Dr.

First name: _____ M.I. _____ Last name: _____ I like to be called: _____

Sex: ☐ M ☐ F Birth date: _____ SS#: _____ Driver's License #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Stable Union Spouse's name _____

Mailing address: _____ City _____ State _____ Zip _____

Employer: _____ Occupation: _____

Cell (___) _____ Home (___) _____ Work (___) _____

Preferred phone for contact: ☐ Cell ☐ Home ☐ Work Email: _____

Whom may we thank for referring you to our practice? _____

PERSON TO CONTACT IN AN EMERGENCY

Name _____ Tel. (____) _____ Relation _____

PHARMACY INFORMATION

Name: _____ Street address: _____ Phone #: _____

City: _____ State: _____ Zip Code: _____

DENTAL INSURANCE INFORMATION

Insurance Co. name _____ Insurance Co. Ph. # _____ Group # _____

Subscriber's name _____ Subscriber's ID # _____

Relationship to patient _____ Subscriber's DOB _____ Subscriber's SS# _____

Street address: (if different from patient's) _____ City _____ State ____ Zip _____

Subscriber's employer _____

MEDICAL INSURANCE INFORMATION

Insurance Co. name _____ Insurance Co. Ph. # _____ Group # _____

Subscriber's name _____ Subscriber's ID # _____

Relationship to patient _____ Subscriber's DOB _____ Subscriber's SS# _____

Street address: (if different from patient's) _____ City _____ State _____ Zip _____

Secondary medical insurance (if applicable) _____ Insurance Co.'s Ph # _____

Group # _____ Subscriber's name _____ Relationship to patient _____ Subscriber's ID# _____

DENTAL HISTORY

Reason for today's visit: _____

Who is your current general dentist? _____ Tel. (_____) _____

How long have you been under the care of your current dentist? _____

Previous dental care has been: ☐ Regular, every _____ month(S) ☐ Irregular

When was your last dental exam and/or hygiene appointment? _____

How often do you brush your teeth? _____ How often do you floss? _____

Please, indicate any of the following problems by checking off the corresponding box:

Are you in pain or having any discomfort in your mouth? ☐ Yes ☐ No If yes, please specify _____

Do you have fear or anxiety towards dental procedures? ☐ Yes ☐ No

Do you have red, swollen, or bleeding gums? ☐ Yes ☐ No

Do you have recurrent blisters or sores in or around your mouth? ☐ Yes ☐ No

Do you have tooth sensitivity to cold, hot, or sweets? ☐ Yes ☐ No

Does food get frequently caught between your teeth? ☐ Yes ☐ No

Do you have a dry mouth? ☐ Yes ☐ No

Do you have TMJ problems, discomfort, clicking, or popping of the jaws? ☐ Yes ☐ No

Have you had any head, neck, or jaw injuries? ☐ Yes ☐ N

MEDICAL HISTORY

Do you need to be PRE-MEDICATED for dental appointments? ☐ Yes ☐ No Reason: _____

Are you in good health ☐ Yes ☐ No Age _____ Height _____ Weight _____

Are you under the care of a physician? ☐ Yes ☐ No

Medical doctor(s): _____ Phone: (_____) _____

Medications (Rx or over the counter you currently take) _____

_____

When was your last complete physical exam? _____

Do you smoke? ☐ Yes ☐ No I f yes, for how long? _____ How many cigarettes per day? _____

Do you use alcohol? _____ If so, how much _____

If you do not smoke, have you ever smoked? ☐ Yes ☐ No For how long? _____ When did you quit? _____

Do you chew tobacco or use any other form of recreational smoking? ☐ Yes ☐ No

Are you currently taking blood thinners (such as Coumadin, Xarelto, Aspirin, etc.): ☐ Yes ☐ No

Are you currently taking bisphosphonates (such as Fosamax, Actonel, etc.)? ☐ Yes ☐ No For how long? _____

Have you had any severe illness or hospitalization? ☐ Yes ☐ No

Do you have, or have you had, any of the following diseases, medical conditions, or procedures?

Y	N		Y	N		Y	N	
☐	☐	A-Fib	☐	☐	Eye Disease/Glaucoma	☐	☐	Osteoporosis
☐	☐	AIDS	☐	☐	Fainting or Dizzy Spells	☐	☐	Pneumonia/Bronchitis
☐	☐	Alcoholism	☐	☐	Gallbladder Problems	☐	☐	Problems with Healing
☐	☐	Allergies or Hives	☐	☐	Hay Fever	☐	☐	Psychiatric Care
☐	☐	Anemia	☐	☐	Heart Attack(s)	☐	☐	Radiation
☐	☐	Arthritis/Joint Disease	☐	☐	Heart Murmur	☐	☐	Respiratory Problems
☐	☐	Asthma	☐	☐	Heart Surgery(s)	☐	☐	Rheumatic Fever
☐	☐	Benign Tumors	☐	☐	Hepatitis A	☐	☐	Rheumatism
☐	☐	Blood Disorders	☐	☐	Hepatitis B	☐	☐	Seizures/Epilepsy
☐	☐	Blood Transfusion	☐	☐	Hepatitis C	☐	☐	Sinus Allergies
☐	☐	Bruise Easily	☐	☐	Herpes	☐	☐	Sinus Infections
☐	☐	Cancer	☐	☐	High Blood Pressure	☐	☐	Snoring/Sleep Apnea
☐	☐	Cardiac Pacemaker	☐	☐	High Cholesterol	☐	☐	Stomach Ulcers
☐	☐	Cardiac Stents	☐	☐	HIV Positive	☐	☐	Stroke
☐	☐	Chemotherapy	☐	☐	Immunosuppression	☐	☐	Sudden Weight Change
☐	☐	Chest Pain/Angina	☐	☐	Irregular Heartbeat	☐	☐	Swollen Ankles
☐	☐	Chronic Fatigue	☐	☐	Joint Replacement	☐	☐	Thyroid Disorders
☐	☐	Contagious Disease	☐	☐	Kidney Disorders	☐	☐	Tuberculosis
☐	☐	Cortisone Medication	☐	☐	Mitral Valve Prolapse	☐	☐	Venereal Diseases
☐	☐	Cosmetic Surgery	☐	☐	Nervousness	☐	☐	Yellow Jaundice
☐	☐	Diabetes	☐	☐	Osteonecrosis			
☐	☐	Drug History	☐	☐	Osteopenia			

ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:

Local Anesthesia (Novocain, etc.)? ☐ Yes ☐ No

Penicillin or other antibiotics? ☐ Yes ☐ No

Sedatives, Barbiturates? ☐ Yes ☐ No

Aspirin or Ibuprofen? ☐ Yes ☐ No

Codeine or other painkillers? ☐ Yes ☐ No

Latex or Rubber products? ☐ Yes ☐ No

Other allergies or reactions? ☐ Yes ☐ No

FOR WOMEN ONLY

Are you pregnant, or is there any chance you might be pregnant? ☐ Yes ☐ No

Are you nursing? ☐ Yes ☐ No

Are you taking birth control pills? ☐ Yes ☐ No

Please, list _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or health practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand that it is my responsibility to collect money from my insurance company. I agree to be responsible and pay in full all services rendered on my behalf of my dependents. I understand that payment is due when services are rendered. ***A NOTICE OF CANCELLATION IS REQUIRED 24 HOURS PRIOR TO SCHEDULED APPOINTMENT TIME. IF A NOTICE I5 NOT GIVEN A CHARGE WILL BE MADE FOR THE TIME SCHEDULED.***

Patient (or Responsible Party and Relationship with the Patient) _____ Date _____

Dr. Review _____ Date _____

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Written Financial Policy

Thank you for choosing Texas Dental Solutions. Our primary mission is to deliver the best and most comprehensive Dental/Medical care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

PAYMENT OPTIONS
You can choose from:

– Cash, Check, Money order, Visa, MasterCard, American Express, or Discover Card

– NO INTEREST [1] Payment Plans from CareCredit and Sunbit
  • Allows you to pay over time with NO INTEREST [1]
  • Convenient, low monthly payment plans are also available (Subject to credit approval)
  • No annual fees or pre-payment penalties

The patient is responsible for payment at the time of the visit. We will file your insurance as a courtesy. Our office does not accept insurance as a form of payment. I understand that Mireya Imitola, DDS, and Bruce Barbash, DDS are out-of-network providers for my insurance company. I understand that all the services performed may not be covered by my insurance contract. I understand that my insurance contract may not pay 100% of Dr. Mireya Imitola' s and Dr. Bruce Barbash's submitted fees.

Payment for all dental procedures is due at the time of service.

- We are not taking responsibility for you or us receiving payment from your insurance company.
- We will mail or electronically file your claim form to the insurance company following services rendered.
- We will also assist you in filing the claim by sending any necessary documents and/or narratives.
- We will not follow up with any dental insurance claims unless the insurance company requests additional information.
- Our office does not guarantee that your insurance company will pay for the treatment that you receive in our office.
- **Although we are willing to complete insurance forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction.** Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement.

Medical services under $2,500 are due at the time services are rendered. Medical services greater than $2,500 require a 50-70% deposit at the time services are rendered. I agree to pay the remainder balance by the time services are completed.

It is important to understand that the contract regarding your Dental and Medical benefits is between you, your employer, and your insurance company.

_____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

1-Offered for services over $2,000. If paid within the promotional period. Otherwise, interest is assessed from the purchase date.

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Authorization to Share Health Care Information

Patient's name:_____ Date of birth:_____

I authorize Dr. Barbash, Dr. Imitola, and their staff to discuss my care with the persons listed below:

Name:_____

Relationship: _____

Name: _____

Relationship:_____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

Name: _____

Relationship: _____

_____ _____

Signature of patient or patient's authorized representative Date signed

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Acknowledgement of Receipt of Notice of Privacy Practices
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices

Review our Notice of Privacy Practices for a complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of Your Protected Health Information

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information

You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed-upon restriction will be a violation of Federal privacy standards.

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below, I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient Full Name _____

Witness Signature