Park Cities Dental Group

Patient Information

Park Cities Dental Group
3110 Webb Ave | Suite 300 • Dallas, TX 75205
(214)528-7870
www.parkcitiesdentalgroup.com

Last Name 1
-

First Name
-

Middle Name
-

Preferred Name
-

Employer
-

Occupation
-

Sex
-

Marital Status
-

Date of Birth
-

Social Security Number
-

Email
-

Best time to call
-

Home Phone
-

Mobile Phone
-

Work Phone
-

Street Address
-

City
-

State
-

ZIP Code
-

Whom may we thank for referring you?
-

Primary Dental Insurance

Name of Primary Subscriber:
-

Date of Birth of Primary Subscriber
-

Insured's Employer Name:
-

Insurance Plan Name:
-

Insurance Phone Number
-

ID #
-

Group #
-

Patient's relationship to insured:
-

Dental History

Reason for Today's Visit
-

Former Dentist
-

Date of Last Dental Visit
-

Are you happy with the appearance of your smile?
-

If not, what would you like to change about it?
-

Would you like to hear about some of the newest options in teeth whitening?
-

Are you interested in learning more about Invisalign?

-

Please check if you have experienced any of the following:

- ☐ Bleeding Gums
- ☐ Bad Dental Experience
- ☐ Burning Sensations
- ☐ Problem Fillings
- ☐ Tobacco Use
- ☐ Dry Mouth
- ☐ Fingernail Biting
- ☐ Food Collection B/T Teeth
- ☐ Grinding Teeth
- ☐ Swollen or Tender Gums
- ☐ Lip or Cheek Biting
- ☐ Loose Teeth
- ☐ Mouth Breathing
- ☐ Orthodontics
- ☐ Fever Blisters
- ☐ Mouth Sores
- ☐ Gum Treatment
- ☐ Pain Around Ear
- ☐ Cold Sensitivity
- ☐ Hot Sensitivity
- ☐ Biting Sensitivity
- ☐ Sweet Sensitivity

How often do you floss?

- ☐ Never
- ☐ Occasionally
- ☐ Frequently
- ☐ Daily

How often do you brush?

- ☐ Once a day
- ☐ Twice a day
- ☐ After each meal

Medical History Form

Patient Information - Health History

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Physician Name:
-

Physician Phone:
-

Do you have a preferred pharmacy?
-

Please list all current medical conditions including any recent surgeries or hospital visits.
-

Please list all current prescription medications including over the counter medications and vitamins.
-

Please list all current allergies including reactions to local anesthetics.
-

HAVE YOU EVER TAKEN ANY BISPHOSPHONATES? (osteoporosis medications, Fosamax)
-

Please check all that apply (a checked box indicates a YES response and an unchecked box indicates a NO response)

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Hearing Impairment
- ☐ Heart Attack/Failure
- ☐ Heart Murmur
- ☐ Heart Pacemaker
- ☐ Heart Trouble/Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Irregular Heartbeat
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Osteoporosis
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Pondimin/Fen-Phen
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sleep Apnea
- ☐ Spina Bifida
- ☐ Stomach/Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ TMJ
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Vision Loss/Blindness
- ☐ Yellow Jaundice

Female only Conditions

☐ Pregnant ☐ Nursing ☐ Taking Oral Contraceptives

Sign and Date

-

☐ By checking this box, I acknowledge that the information I have provided is accurate and to the best of my knowledge. *

Office Policies

General Consent

I grant my permission for Dr. Smith, Dr. Allison, and/or Dr. Hino to perform an examination and/or other forms of testing in order to assess my oral health.

I grant my permission to telephone me at home or work to discuss matters related to this practice.

We communicate through unencrypted email. By agreeing here, you consent to continued communication without encryption. By declining you request all correspondence be via traditional mail.

Our fees are valid for 90 days. Fees are subject to change without notice. PPO fees are subject to change according to the carrier.

Sign

-

Date

-

Payment Policy

Same day procedures must be paid in full

Multi day procedures must be paid in full by the last treatment date.

Crowns/implants/bridges will not be cemented until the appearance is approved by you. Changes can be made at no charge before cementing. Changes made afterwards will be at full fee.

We warranty all work for one year for breakage or fracture. Replacement will be at no cost. Replacement after one year will be at full fee.

No Show Policy

When you make an appointment at Park Cities Dental Group, we reserve a significant amount of time. Unfortunately, when a patient does not show up for their scheduled appointment, another patient loses an opportunity to be seen. Any patient that does not arrive for their scheduled appointment within a 15 minute window is considered a no-show and will be rescheduled.

New Changes in Dental Insurance Plans

Due to the recent and unpredictable changes within the insurance industry, we may or may NOT be a part of your IN-NETWORK benefits. As a courtesy, our team will continue to verify and bill your insurance, but we cannot guarantee coverage or that the information we have received from your carrier and conveyed to you is accurate or complete.

In the event that your dental insurance carrier denies your claim for "OUT OF NETWORK" and you do not have OUT OF NETWORK benefits on your plan, you will be charged a Self-Pay rate for your visit/procedure performed in our office.

In the event that a particular procedure is not covered or covered at a lower rate, regardless of the estimate we provide, you will be responsible for the full quoted amount.

I understand that it is my responsibility to fully understand my insurance benefits and that the benefits quoted to me by this office are based on the information provided to PCDG by my insurance carrier. I understand that PCDG must abide by the rules governing my insurance coverage.

Financial Responsibility

WE ACCEPT LOCAL BANK CHECKS WITH A VALID TEXAS DRIVERS LICENSE ONLY

You may pay with MC, Visa, Discover, AMEX, Care Credit, HSA, FSA or Cash. Patients with dental insurance acknowledge that all dental services are billed to the patient directly, and the patient is personally responsible for the complete payment of all charges incurred.

Estimated payment is required at the time services are rendered. When possible, dental claims will be submitted by Park Cities Dental Group. Occasionally, insurance plans do not pay what they initially indicate. PCDG will make a reasonable attempt to resolve problems with claims, however, insurance claims not paid within 60 days are due in full from the patient

If there remains a balance after insurance issues payment, I will receive a billing statement for the balance, which I will pay within (10) days. All balances still existing 90 days after receipt of insurance payment will be subject to recovery by a collection agency.

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights regarding my protected health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that your office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the address listed above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Sign

-

Date

-