



5819 Highway 6 South, Suite 230
Missouri City, Texas 77459
(281) 499-3541

Welcome! We are pleased that you have chosen us to care for your dental health. Please help us by taking a minute to fill out both sides of this form. We promise that all of this information will remain confidential.

Date: _____

PATIENT INFORMATION

Name: _____
(Last) (First) (Middle Initial) (Nickname)

Home Address: _____
(Street)

(City) (State) (Zip Code)

Home Telephone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Social Security Number: _____ Driver License No: _____

Sex: _____ Marital Status: _____

Spouse's Name: _____ Emergency Contact No.: _____

Preferred Dentist: _____

Patient's Employer: _____

Employer's Address: _____
(Street) (City) (State) (Zip Code)

Business Phone: _____ Present Position: _____

Who may we thank for referring you to us? _____

BILLING INFORMATION

Person Responsible for Bill: _____
(Last) (First) (Middle Initial)

Social Security Number: _____ Date of Birth: _____

Responsible Party's Address: _____
(Street)

(City) (State) (Zip Code)

Responsible Party's Home Telephone: _____ Business Telephone: _____

Responsible Party's Employer: _____

Employer's Address: _____

INSURANCE INFORMATION

As a courtesy, we will accept payment of benefits directly from your insurance company. Please fill this part out accurately and completely. The part of our fee that is not covered by insurance is due at the time of treatment.

Name of insurance company: _____

Address of insurance company: _____
(Street) (City) (State) (Zip Code)

Name of insured: _____

Group Number: _____ Social Security Number: _____

Date of Birth of Insured: _____ ID or Clock #: _____

Telephone Number of Insurance Company: _____

Name of secondary insurance company: _____

Address of secondary insurance company: _____
(Street) (City) (State) (Zip Code)

Name of insured: _____

Group Number: _____ Social Security Number: _____

Date of Birth of Insured: _____ ID or Clock #: _____

Telephone Number of Secondary Insurance Company: _____

MEDICAL HISTORY

PATIENT NAME: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? Yes No N/A _____
- Have you ever been hospitalized or had a major operation? Yes No N/A _____
- Have you ever had a serious head or neck injury? Yes No N/A _____
- Are you taking medications, pills or drugs? Yes No N/A _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No N/A _____
- Are you on a special diet? Yes No N/A _____
- Do you use tobacco? Yes No N/A _____
- Do you use controlled substances? Yes No N/A _____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following? _____

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

Do you have or have you had, any of the following? _____

- | | | | | |
|--|--|--|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> Chest Pains | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Anaphylaxis | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Sickle Cell Disease |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Convulsions | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Sinus Trouble |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Cortisone Medicine | <input type="checkbox"/> Heart Attack / Failure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur* | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Stomach/ Intestinal Disease |
| <input type="checkbox"/> Artificial Heart Valve* | <input type="checkbox"/> Drug Addiction | <input type="checkbox"/> Heart Pace Maker* | <input type="checkbox"/> Mitral Valve Prolapse* | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Artificial Joint* | <input type="checkbox"/> Easily Winded | <input type="checkbox"/> Heart Trouble / Disease | <input type="checkbox"/> Pain in Jaw Joints | <input type="checkbox"/> Swelling of Limbs |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Parathyroid Disease | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Psychiatric Care | <input type="checkbox"/> Tonsillitis |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Hepatitis B or C | <input type="checkbox"/> Radiation Treatments | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Breathing Problem | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Herpes | <input type="checkbox"/> Recent Weight Loss | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Renal Dialysis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Frequent Cough | <input type="checkbox"/> Hives or Rash | <input type="checkbox"/> Rheumatic Fever* | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Frequent Diarrhea | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Yellow Jaundice |

Have you ever had any serious illness not listed above? Yes No N/A _____

Please list all medications you are currently taking: _____

* condition may require medication

N/A – Not answered by patient

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

DATE



General Dentistry

James D. Condrey D.D.S.

Randal M. Glenn, D.D.S.

Ron C. Hill, D.D.S.

Brian K. Machart, D.D.S.

This office is happy to help you process your insurance claim. We will complete our portion of the claim form and mail or electronically transmit your claim form promptly at no charge. We do, however, include patients with dental insurance in our normal monthly billing cycle. You will, therefore, receive a statement at the first of every month until you or your insurance company pays your bill in full. For any services other than preventative, you will be responsible for your deductible (if it has not been met) and your *estimated* portion of the fee *at the time of service*. The remaining balance is due no later than 30 days after the insurance company has paid their portion unless a written and signed payment plan is on file in your chart. Any claims not paid within 60 days will be the responsibility of the patient and must be paid. Any disputes regarding the amounts paid will be *between you and your insurance company*. We will gladly supply any information requested by the insurance company. If payment is not received, we will take necessary action through our collection agency to make certain that the fee for the services rendered to you is paid.

The agreement for dental services is between the doctor and the patient, *not with the insurance company of any third party payor*. Therefore, should the claim for the service be rejected or applied to the patient's deductible, the patient is ultimately responsible for payment to this office. Insurance coverage is limited to a *portion* of the fee agreed to by you in our office. There is categorically no such thing as a UCR fee for any nation, state, or zip code that is not created internally by the insurance industry. The limits of your coverage are based upon such things as premium amounts paid by your employer and profit margins designed by the insurance companies. The insurance companies are solely responsible for those numbers and they vary from company to company. When you receive treatment in this office, you agree to be financially responsible for the *entire fee*, independent of your insurance coverage. The *only* exception to this policy is if you are a member of a PPO plan of which we are members and we have agreed to their contracted fees. However, should they deny coverage for any reason, you will still be responsible for the contracted fee in full.

I accept the above terms. I read and understand English and I authorize payment of insurance benefits directly to Fort Bend Dental Associates.

Signature of Patient / Guarantor

Date

I read and speak English and I authorize release of all necessary information to my insurance carrier and their representatives.

Signature of Patient

Date