Heaton Dental

3806 Brookside Dr.
Tyler, TX 75701

Phone: 903 561-1122 OR 903-595-4246
heatondental@gmail.com

PATIENT INFORMATION

Name:_____
Last First Middle Preferred

Address: _____
Street/Apt # City State Zip

Phone: H _____ W_____ Cell_____ Preferred Contact: _____

Date of Birth: _____ Sex: _____ Marital status:_____ SS#: _____

Employer: _____ Email address:_____

Dental Insurance: Y or N *Please, provide copy of Photo ID and dental card.*

Insurance Company: _____ Phone Number: _____

Policy Holder_____ DOB _____ ID/SS _____

Ins Group#_____ Employer name(if applies)_____

Whom may we thank for referring you : _____

___ I agree to allow my insurance (if applicable) to be filed electronically by Stansbury Dental.

DENTAL HISTORY

Do you have dental exams on a routine basis? _____ Last visit: _____ Last x-rays:_____

Chief Concern today: _____

Is there anything about your smile you'd like to improve? _____

Do you have any old filings or dental work that needs improvement? _____

Are you nervous about dental treatment? _____

Do you clench or grind your teeth? _____

Have you used Nitrous Oxide (gas) for treatment? _____

MEDICAL HISTORY

Circle if you ever had (or suspected of having) any of the following:

AIDS/HIV	Bladder Problems	Diabetes	Kidney
Allergy Seasonal/Sinus	Bleeding Disorder	Emphysema	Lung Disease
Anemia	Bruise Easily	Fainting/Weakness	Rheumatic /Scarlet Fever
Asthma	Cancer/Radiation	Heart Condition	Seizures/Epilepsy
Artificial Joints	Chest Pain	Hepatitis- A B C	Stomach/Esophageal
Back Problems	Depression	High BP	Thyroid

(PLEASE LIST CURRENT MEDICATIONS BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

Detail other conditions we may need to know:

_____

_____

Allergies (circle): Acrylic Aspirin Codeine Latex Metal Penicillin Sulfa Other: _____

Need for pre-med antibiotic: Yes No Pregnant/trying to get pregnant: Yes No

Primary Care Physician: _____ phone: _____

Specialist Care (if applicable): _____ phone: _____

Preferred Pharmacy: _____ phone: _____

Emergency Contact:_____ Relationship: _____ phone:_____

Patient Signature: _____ Date: _____

Notice of Privacy Practices

Please initial each line, sign and date at the bottom

___ I am aware of the Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the legal duties with respect to my information.

___ I understand that this practice reserves the right to change the terms of its Notice and to make changes regarding all protected health information resident at or controlled by the same. I understand I can obtain a copy of the current Notice of Privacy Practices on request.

___ I understand the Dr. Stansbury or his representatives may contact me and leave a message via text, cell phone, work phone or home phone.

Please list any persons that we may inform about your health information. Be aware that these people we have FULL ACCESS to your entire dental/medical record.

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Printed name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Financial Agreement

It is our goal to provide the best possible dental care for you. We realize that financial concerns are unavoidable. Our team wants you to enjoy the benefits of dental health, therefore we are more than happy to work with you to plan the most appropriate arrangements. As a courtesy to our patients, our office staff conducts financial consultations to outline the fees for your treatment to the best of our estimation and to answer any questions that you may have.

Initial _____

Outside Financing Options

Our office has partnered with Care Credit and The Lending Tree: these are medical, dental, optical and veterinarian credit cards. These companies give you the flexibility and convenience to pay over a 6 to 12 month period of time, with the opportunity of avoiding interest. The form to apply can usually be completed within a few minutes.

Initial _____

Assignment of Insurance

We understand the value of insurance benefits to our patients. Rarely does an insurance company cover the entire bill, however, we do our best to estimate your deductible and the portion that will be covered by your carrier. The balance remaining, once the claim is processed is the patients direct responsibility. This may include any non-covered services, yearly deductible or co-payments particular to your insurance plan. Please be aware of your financial responsibilities under the terms of your policy, as we have no influence upon the insurance company's decision to cover any given treatment. We will file claims on your behalf, providing information for them to make pre-determinations. Financial responsibility for services provided to you is ultimately yours, regardless of any decision by your carrier.

Initial _____

I have read the above and understand:

_____ _____

Printed Name Date

_____

Signature