SOUTHWEST DENTAL CARE OF ABILENE, PLLC

Richard L. Gore, D.D.S. Chris W. Proctor, D.D.S.

Name_____ Social Security # _____ Date_____

Occupation_____ Business Name_____

Home Address_____ Business Address_____

_____Zip Code_____ _____Zip Code_____

Home Phone ( )_____Business Phone ( )_____ Cell Phone ( )_____ E-mail_____

Birth Date _____ Age _____ Sex _____ Race _____

Spouse/Parent Name _____ Spouse/Parent Social Security # _____

Spouse/Parent Business Name _____ Spouse/ Parent Business Phone ( ) _____

Whom may we thank for referring you? _____

Charges for first time visits are due today:

How will you be paying for today's visit? ☐ Check ☐ Cash ☐ MC/Visa/Discover Driver's License # _____

Do you have Dental Insurance Coverage? Yes No If yes, with what Insurance Company _____

MEDICAL HISTORY

1. Are you now or have you been under the care of a physician in the last 12 months? _____
   For what purpose? _____ Last time at physician? _____
   Physician's name? _____ Address and phone? _____
2. Are you on any medications at the present time? If so, please specify dosage and interval.

   _____

   _____

   _____

   Females only: Do you take oral contraceptives? _____ Are you pregnant? _____
3. Do you have any drug allergies or have you experienced any adverse drug effects? _____

   _____
4. Have you ever had an adverse reaction to local anesthetics, latex gloves, or other dental materials? _____

   _____
5. Have you ever had major surgery? If so, when and why? _____

   _____

   _____

   _____
6. Do you have a history of any of the following conditions?

   Hepatitis _____ Heart Disease _____
   Diabetes _____ Bleeding Disorder _____
   Rheumatic Fever _____ Tuberculosis _____
   Asthma _____ High/Low Blood Pressure _____
   AIDS _____ Heart Murmur _____
   Joint Replacement_____ Seizure Disorder _____
   Thyroid Trouble _____ Radiation/ Chemotherapy_____
7. Does your physician require you to have antibiotics for any reason before dental treatment? _____

   _____
8. Have you ever or do you now use any of the following? If so, please specify type, frequency, and duration.
   Tobacco _____
   Alcohol _____
9. Is there any other pertinent information that you feel will help us to better serve you? _____

   _____

   _____

   _____

   _____

   _____

PRECLINICAL QUESTIONS

	Yes	No
1. Purpose of initial visit:		
a) Routine dental exam		
b) Chief complaint: _____	❑	❑
2. How often do you normally visit a dentist? _____		
When was your last dental visit? _____		
What was done for you at that time:? _____		
3. Are you having any particular problems with your teeth or gums?	❑	❑
_____		
_____		
_____		
4. Do you have any pain or sensitivity in any of your teeth?	❑	❑
_____		
5. Does food catch or wedge between your teeth?	❑	❑
_____		
6. Do you floss? If so, how often? _____	❑	❑
7. Do you clench or grind your teeth? _____	❑	❑
8. Have you ever experienced jaw pain or clicking when opening or closing your mouth? _____	❑	❑
_____		
9. Do you consider yourself to be nervous or anxious about dental treatment? _____	❑	❑
10. How do you feel about your teeth? _____		
_____		
_____		
11. Are you happy with your smile? _____	❑	❑
Is there anything you would like to change about it?	❑	❑
_____		
_____		
12. What can we do to help you? _____		
_____		
_____		

Southwest Dental Care of Abilene, PLLC
Richard L. Gore, DDS & Chris W. Proctor, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, has received a copy of this office's
Please Print Name Notice of Privacy Practices.

_____
Signature *Date*

Please list any persons you would allow us to release your information to:

_____

_____

_____

For Office Use Only

We attempted to obtain written acknowledge of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

- o Individual refused to sign
- o Communication barrier prohibited obtaining the acknowledgement
- o An emergency situation prevented us from obtaining acknowledgement
- o Other *(Please Specify)*

_____

Southwest Dental Care of Abilene, PLLC

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As your dentist and staff, we are committed to providing you with the best possible dental care, service, and courtesy. Payment for these services is due at the time they are rendered. We accept **CASH, CHECKS**, and any **MAJOR CREDIT CARDS**.

Dental Insurance: We are eager to help you receive your maximum allowable benefit from your insurance company. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

We will be happy to process your insurance claim for your reimbursement. We also, accept assignment of insurance benefits, if you provide, in advance, all necessary information needed to properly process the claim. This includes, but is not limited to, a completed claim form and a copy of your insurance card. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date the services are rendered. You will be expected to pay your estimated portion at the time of service.

Since most insurance companies respond more effectively to the insured we would appreciate your assistance in collecting payment from your insurance company. If payment has not been received from your insurance company within 45 days, we will bill you the balance on the account.

Returned checks and Balances over 30 Days: Are subject to additional collections fees and/or interest charges of 1% per month.

Appointment Cancellations: We request a **24 HOUR NOTICE** unless under emergency circumstances.

Patient Authorization: I understand the above financial arrangements. I hereby authorize any physician, hospital, or medical facility to provide all information on my medical history and treatment to Southwest Dental Care. I hereby authorize Southwest Dental Care to release any information acquired in the course of my examination of treatment. I hereby authorize and direct payment to Southwest Dental Care for the dental benefits, if any, otherwise payable to me under terms of my insurance. I hereby authorize photocopies of this form to be as valid as the original.

DATE _____ **SIGNED** _____