

HEALTH HISTORY

Date _____ Patient Name _____ Name you wish to be called _____
 Physical Address _____ Home Phone _____
 City _____ State _____ Zip Code _____ Work Phone _____
 Mailing Address _____
 City _____ State _____ Zip Code _____
 Best Time and Place to Reach You _____ Email _____
 Sex: M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced Domestic Partner
 Patient SS # _____ Occupation _____ Employer _____
 Employer Address _____ Employer Phone _____
 Spouse Name _____ Birthdate _____ SS# _____
 Occupation _____ Spouse's Employer _____

IN CASE OF EMERGENCY PLEASE CONTACT (someone not living with you)

Name _____ Relationship to you _____
 Address and Phone Number of Emergency Contact Person _____
 Whom may we thank for referring you? _____
 Who is responsible for this account? _____ Relationship to patient _____

Insurance Company _____ Group # _____
 Is patient covered by additional insurance? yes no Subscriber's name _____
 Subscriber's Birthdate _____ Subscriber's SS# _____ Relationship to Patient _____
 Insurance company _____ Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____
 and assign directly to doctor otherwise payable to me for services rendered. I understand that I am financially responsible for all
 charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment
 of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature	Relationship	Date
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DENTAL HISTORY

Reason for today's visit _____
 Former Dentist _____ City/State _____
 Date of last dental visit _____ Date of last dental X-rays _____
 Please check Yes or No to indicate if you have had any of the following:

Bad breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleeding gums	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blisters on lips or mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Burning sensation	<input type="checkbox"/> Yes <input type="checkbox"/> No	Chew on one	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarette, pipe or	
on tongue		side of mouth		cigar smoking	<input type="checkbox"/> Yes <input type="checkbox"/> No
Clicking or popping	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dry mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fingernail biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw		Food collection		Chewing tobacco	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you or have you		between teeth		Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
ever experienced		Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No	Lip or cheek biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
pain/discomfort		Jaw pain or	<input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
in your jaw joint	<input type="checkbox"/> Yes <input type="checkbox"/> No	tiredness		Gums swollen or	<input type="checkbox"/> Yes <input type="checkbox"/> No
Food collection	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting	<input type="checkbox"/> Yes <input type="checkbox"/> No
tender		breathing		Do you like your smile	<input type="checkbox"/> Yes <input type="checkbox"/> No
Periodontal	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type of bristles <input type="checkbox"/> Hard <input type="checkbox"/> Medium <input type="checkbox"/> Soft	
Loose teeth or	<input type="checkbox"/> Yes <input type="checkbox"/> No	treatment		Have you ever had a	
broken fillings		Sensitivity to	<input type="checkbox"/> Yes <input type="checkbox"/> No	serious or difficult	
Pain around ear	<input type="checkbox"/> Yes <input type="checkbox"/> No	sweets		problem associated with	
Sensitivity to heat	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss _____		previous dental work	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sores or growths in	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____			
your mouth					

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Please check yes or no to indicate if you have had any of the following:

AIDS	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis,	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatism		Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial heart	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
valves		Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Type _____		Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
(with extractions or surgery)		Meds: _____		Swelling of Feet or	
	<input type="checkbox"/> Yes <input type="checkbox"/> No	HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Joint replacement	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory		Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on	
problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Head or Neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart		Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone		Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss,	
treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Women:		unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, Persistent or		Are you pregnant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Any hospital stays	<input type="checkbox"/> Yes <input type="checkbox"/> No
bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Due date _____		Explain _____	
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Are you nursing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	
Do you wear		Are you taking birth		_____	
Contact lenses	<input type="checkbox"/> Yes <input type="checkbox"/> No	control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	

MEDICATIONS

Please list medications you are currently taking:

Pharmacy Name _____
Phone _____

ALLERGIES

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Local Anesthetic
<input type="checkbox"/> Barbiturates (sleeping pills)	<input type="checkbox"/> Penicillin
<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa
<input type="checkbox"/> Iodine	<input type="checkbox"/> Other _____
<input type="checkbox"/> Latex	_____

I understand I am responsible for my account regardless of my insurance. I also understand that my insurance is an agreement between me and my insurance company.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days.

I give permission for my dentist and clinical team to take any necessary radiographs, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Patient's Signature

Date

Doctor's Signature
(I have read, agree to, and understand the statements listed above)

Date

Sandeep B. Patel, DDS, P.A.
Onion Creek Family Dentistry
11215 S I H 35, Ste116 | AUSTIN TX, 78747 | (512) 233-6200
Onioncreekdental@sbcglobal.net , Onioncreekdental.com

Written Financial Policy

Thank you for choosing Onion Creek Family Dentistry. Our primary mission is to deliver the best and most comprehensive dental 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:

- Check, Visa, Mastercard, American Express, Discover Card, Cash

We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care for treatment plans of \$1000 or more.

- NO INTEREST¹ Payment Plans² from CareCredit

- o Allow you to pay over time with NO INTEREST¹
- o Convenient, low monthly payment plans² also available
- o No annual fees or pre-payment penalties

Please note:

Onion Creek Family Dentistry requires payment at the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. ***Insurance is a contract between you and your insurance company; therefore, you are still responsible for the timely payment of your account in the event the insurance company does not cover the cost of treatment.***

A fee of \$50 is charged for patients who **miss** or **cancel without 24-hour notice**.

Onion Creek Family Dentistry charges all Forwarding bank fees for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)