PATIENT INFORMATION

Name:_____Occupation:_____

Address:_____Male____Female____

City:_____ State:_____ Zip:_____Phone: _____

Employer:_____Work Number:_____

DOB: _____ SSN: _____ Email: _____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name: _____ Address: _____

City:_____State:_____ZIP:_____DOB:_____

SSN:_____Cell:_____ Relationship:_____

SOME OF OUR SERVICE MAY BE COVERED BY YOUR MEDICAL INSURANCE

Medical Insurance

Ins. Company Name:_____Subscriber Name:_____

Policy Number:_____Group Number:_____

Address:_____Phone Number:_____

Relationship to the Patient:_____ DOB:_____ SSN:_____

Dental Insurance

Ins. Company Name:_____Subscriber Name:_____

Policy Number:_____Group Number:_____

Address:_____Phone Number:_____

Relationship to the Patient:_____ DOB:_____ SSN:_____

WHAT IS MOST IMPORTANT TO YOU IN A DENTIST, DENTAL TEAM, AND ORAL HEALTH

_____

_____

DO YOU HAVE ANY COSMETIC CONCERNS THE DOCTOR SHOULD BE AWARE OF

_____

_____

I AUTHORIZE THE DENTIST TO PERFORM DIAGNOSTIC PROCEDURES AND TREATMENT AS MAY BE NECESSARY FOR PROPER DENTAL CARE. I ALSO AUTHORIZE THE RELEASE OF ANY INFORMATION CONCERNING MY (OR MY CHILDS) HEALTH CARE, MEDICAL HISTORY, ADVICE AND TREATMENT TO ANOTHER DENTIST IF APPLICABLE OR AN INSURANCE COMPANY. SINCE APPOINTMENTS ARE RESERVED EXCLUSIVLY FOR ME, I UNDERSTAND THAT CHARGES WILL OCCUR IF I GIVE LESS THAN 48 HOUR NOTICE OF AN APPOINTMENT CANCELLATION.

SIGNATURE: _____ **DATE:** _____

PATIENT MEDICAL HISTORY

Name: _____ Date of Birth: _____ Sex: M F **Today's Date:** _____

Primary Care Physician: _____ Physician's Phone: _____

DRUG ALLERGIES	Head/Ears/Nose/Throat	Pulmonary	Musculoskeletal
List all **DRUG Allergies:** _____ _____ _____ _____ _____ _____	☐Visual problems ☐Sore Throat ☐Dry mouth ☐Food Allergy/Sensitivity ☐Seasonal/Other Allergies	☐Asthma ☐Cough ☐Wheezing ☐Shortness of Breath ☐Emphysema/COPD ☐Other	☐Arthritis Rheumatoid/Osteo ☐Joint Pain ☐Back Pain ☐Jaw Pain ☐Joint replacement ☐Osteoporosis
Cardiac	**Gastrointestinal**	**Metabolic**	**Sleep**
☐Chest Pain with Exertion ☐Heart Failure ☐Palpitations/Irregular heart beat ☐Valve Replacement ☐Coronary Artery Disease ☐Heart Attack ☐Endocarditis	☐Abdominal Pain ☐Trouble Swallowing ☐Nausea/ Vomiting ☐Fatty Liver/Liver Disease ☐Stomach Ulcers ☐Heartburn or Acid Reflux ☐Other	☐High Blood Pressure ☐Diabetes ☐High Cholesterol ☐Thyroid Problems ☐Anemia ☐Other_____	Have you ever been told that you snore? ☐YES ☐NO Have you ever taken a test for sleep disordered breathing (Apnea)? ☐YES ☐NO
Hematological	**Psychological**	**Neurological**	
☐Abnormal Bleeding ☐Easy Bruising ☐Blood Clots ☐HIV/AIDS ☐Hepatitis B or C ☐Leukemia	☐Depression ☐Anxiety ☐Stress ☐Mental Illness	☐Neurologic Disease ☐Migraines ☐Dizziness ☐Passing Out ☐Seizure/Epilepsy ☐Stroke	Do you: **SMOKE?** **Y/N**____packs/day x ___years **Use of TOBACCO?** **Y/N**_____How/How Often?

***ARE YOU TAKING ANY BLOOD THINNERS?...** ☐ **YES** ☐ **NO**
Medications for osteoporosis?... ☐ **YES** ☐ **NO**
Pre-med for dental appointment?... ☐ **YES** ☐ **NO**

List current medications below. (If you have a pre-existing list, we will accept that as well)	**Reason for Taking**

Patient Signature_____ **Date:**_____
Patient Signature_____ **Date:**_____
Patient Signature_____ **Date:**_____
Patient Signature_____ **Date:**_____
Patient Signature_____ **Date:**_____

APPOINTMENT CANCELLATION POLICY

We Pride ourselves in providing extra time for the personal attention each patient deserves. We respect your time and make every effort to keep you from waiting. As a result, your appointment time, in this office is reserved exclusively for you.

HOW TO CANCEL YOUR APPOINTMENT

To be respectful of the needs of all Horseshoe Bay Dental patients, If it is necessary to cancel your reserved appointment, we **require that you verbally contact our office 48hrs in advance.** Appointments are in high demand and your early cancellation will give another person the possibility to access timely dental care. *Cancellations within 24hrs of your appointment will be charged $100.00*

"NO Show" appointments will be charged your appointment fee in full starting at a minimum of $300.00 for Dr Sopel patients and $100.00 for Hygiene.

After the first "NO Show" appointment, all other appointments will need to be pre-paid in full at the time the appointment is scheduled. If the patient has (3) last- minute cancelations or missed appointments, in a twelve-month period, we reserve the right to terminate the patient/doctor relationship. If the patient has (3) last- minute cancelations or missed appointments, in a twelve-month period, we reserve the right to terminate the patient/doctor relationship.

INSURANCE

To better assist you, we do **require** all insurance information and verification **48** hours prior to your appointment. We bill your insurance as a courtesy. If insurance does not pay within 90 days, Horseshoe Bay Dental reserves the right to full payment for your services. This is rare, but it is important that you recognize that the insurance you have, is a legal contract between **YOU and your Insurance company**. Ultimately, you are responsible for all charges incurred in our office.

By Signing below, I certify that I have read and understand the terms and conditions of Horseshoe Bay Dental appointment cancellation policy:

please sign & date ----------

Horseshoe Bay Dental

9000 Hwy 2147 West Ste, 103 Horseshoe Bay, TX 78654 Phone (830)598-5474

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of this Dental Practice's HIPAA Notice of Privacy Practices.

_____

Patient Name (Please Print)

_____

Patient Signature

_____

Date

_____

Signature of Personal Representative