Patient Information

Patient Name:_____ Date:_____
Last First (Preferred Name)

Gender:____ Family Status:_____ Social Security #:_____ Birth Date:_____

Phone (H):_____ (W):_____ (CELL):_____ (O):_____

Email:_____ Best Way To Be Reached:_____

Address:_____
Street Apartment #

_____
City State Zip Code

Patient Employer:_____ Address:_____

In Case of an Emergency Contact:_____ Relationship:_____

Address:_____ Phone:_____

Who May We Thank For Referring You To The Practice:_____

Date of Last Dental Visit:_____ Reason For Today's Visit:_____

Insurance Information

Subscriber of Insurance Policy:_____ Subscriber's Birth Date:_____

Subscriber's Social Security #:_____ Subscriber's Employer:_____

Name of Insurance Company:_____ Group #:_____ Phone #:_____

Insurance Mailing Address:_____

We are committed to keeping our fees congruent with the quality of dentistry that we deliver. Therefore, we will assist you in maximizing your dental benefits as appropriate for your choice of treatment. Full payment is to be made at the time of treatment and with completed information. Your dental claim will be filed on the date of service.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctor at the next appointment. I authorize diagnostic aids to be taken as deemed appropriate by my doctor such as x-rays, study models, photographs, etc., in order to make a thorough diagnosis of my dental needs. I also authorize my doctor to perform all recommended treatment mutually agreed upon and use of appropriate medication. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that my doctor choose and employ such assistance as deemed fit to provide recommended treatment. I understand that I am responsible for payment for service provided in this office and that payment is due at the time of service. I grant permission to your office to telephone me at home or at my office to discuss matters related to my treatment and to duplicate x-rays that are requested by either myself or another provider's office.

_____ Date:_____
Signature of patient, parent or guardian

_____ Date:_____
Signature of Doctor

4407 Bee Cave Rd, Bldg. 2, Ste. 221, Austin, TX 78746 www.DanMatthewsDDS.com

Dan Matthews, D.D.S., F.A.G.D.
4407 Bee Cave Road
Bldg. 2, Ste. 221
Austin, Texas 78746

Medical History

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 If yes, please explain:_____
Have you ever been hospitalized or had a major operation? ( ) Yes ( ) No If yes, please explain:_____
Have you ever had a serious head injury? ( ) Yes ( ) No If yes, please explain:_____
Are you taking any medications, pills, or drugs? ( ) Yes ( ) No If yes, please explain:_____
Do you take, or have you taken, Phen-Fen or Redux? ( ) Yes ( ) No _____
Are you on a special diet? ( ) Yes ( ) No _____
Do you use tobacco? ( ) Yes ( ) No
Do you use controlled substances? ( ) Yes ( ) No

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 If yes, please explain:_____

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

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

Have you ever had any serious illness not listed above? ( ) Yes ( ) No If yes, please explain:_____

Comments:_____

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 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:_____

Dan Matthews, D.D.S., F.A.G.D.
4407 Bee Cave Road
Bldg. 2, Ste. 221
Austin, Texas 78746

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain right to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Policies from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Relationship to Patient: _____

Date: _____

Dan Matthews, D.D.S., F.A.G.D.
4407 Bee Cave Road
Bldg. 2, Ste. 221
Austin, Texas 78746

Appointment Cancellation Policy
Effective January 1, 2010

All patients receive a complimentary phone call, email, and/or text message reminder the day before scheduled appointments.

We request that all patients extend a **courteous 24 hour cancellation notice** to change or cancel **ANY** appointment. Failure to do this will result in a **$50.00 charge**.

Restorative procedures of **$50.00** or greater value will require a **non-refundable $50.00 deposit** to reserve your appointment. This amount will be deducted from the procedure charge. In case of failure to give a 24 hour cancellation or reschedule notice, the deposit is **non-refundable**.

Name:_____

Date:_____