Burleson Smiles Dentistry

1304 NW John Jones Dr. Burleson, Texas 76028

Please take a few minutes to answer the following
Questions so we can better assist you with your dental needs. Date: _____

PATIENT INFORMATION

Name_____
Last Name First Name Initial

Address_____ Home Phone_____ Cell Phone_____

City_____ State_____ Zip_____ Email Address_____

Employer_____ Occupation_____ Work Phone_____

Sex __ M __F Marital Status_____ Birthday_____ Soc.Sec._____

DL#_____ Person responsible for account_____

How did you hear about us? _____

In case of emergency, who should we contact?_____

PRIMARY DENTAL INSURANCE

Insured's name_____
Last Name First Name Initial

Relationship to Patient_____Birthday_____Soc.Sec._____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Work Phone_____

Primary Insured Employer_____

Insurance Company_____ Insurance Phone_____

Insurance Company Address_____

Subscriber I.D_____ Group Number_____

SECONDARY DENTAL INSURANCE

Insured's name_____
Last Name First Name Initial

Relationship to Patient_____Birthday_____Soc.Sec._____

Address_____ Home Phone_____

City_____ State_____ Zip_____ Work Phone_____

Secondary Insured Employer_____

Insurance Company_____ Insurance Phone_____

Insurance Company Address_____

Subscriber I.D_____ Group Number_____

The above information is true and accurate to the best of my knowledge.

Assignment and Release: I hereby authorize payment directly to Chris hawkins, DDS, PC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, regardless of whether they are paid by insurance, and all services rendered on my behalf or my dependents. I authorize the above doctorand/or any provider of services in this office to release the information required to secure payment of benefits. I authorize the use of this signature on all insurance submissions.

Signature of Responsible Party: _____Date_____

Dr Christopher A. Hawkins, D.D.S.
Burleson Smiles Dentistry
1304 NW John Jones Drive
Burleson, TX 76028

HEALTH HISTORY

Patient Name _____ Today's Date _____

Birthdate _____ ☐ Male ☐Female Height _____ Weight _____

Are you in good health? ☐Yes ☐No Have there been any changes in your health in the past year? ☐Yes ☐No

Primary Care Physician _____ Cardiologist _____

List all conditions and illnesses for which you are currently being treated:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

List any surgeries or hospitalizations along with dates of treatment:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Do you have a prosthetic joint or implant? ☐Yes ☐No If so, where? _____

Have you had a heart valve replacement or vascular graft? ☐Yes ☐No

Are you taking or have you ever taken bisphosphonates (Fosamax, Aredia or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc)? ☐Yes ☐No

MEDICATION

☐Yes ☐No Blood Thinners
☐Yes ☐No Antibiotics
☐Yes ☐No Tranquilizers
☐Yes ☐No Pain Medication

Please list all medications:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

ALLERGIES

☐Yes ☐No Local Anesthetic
☐Yes ☐No Antibiotics
☐Yes ☐No Narcotics
☐Yes ☐No Barbituates
☐Yes ☐No Latex
☐Yes ☐No Soy
☐Yes ☐No Eggs/Yolk
☐Yes ☐No Sulfa (a medication)
☐Yes ☐No Sulfites (food preservative)

Please list all allergies:

_____
_____
_____
_____
_____
_____

Is there any condition about your health that the doctor should know about? ☐Yes ☐No

Is there anything you would like to speak to the doctor privately about? ☐Yes ☐No

WOMEN ONLY

Are you pregnant or possibly pregnant? ☐Yes ☐No

Expected delivery date:

_____

Are you taking birth control?

☐Yes ☐No

Please note that antibiotics may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Have you had or do you currently have:

☐Yes ☐No	Rheumatic Heart Disease	☐Yes ☐No	Blood Disorder such as Anemia
☐Yes ☐No	Damaged Heart Valves	☐Yes ☐No	Abnormal Bleeding
☐Yes ☐No	Mitral Valve Prolapse	☐Yes ☐No	Fainting Spells
☐Yes ☐No	Heart Murmur	☐Yes ☐No	Convulsions/Seizures
☐Yes ☐No	High Blood Pressure	☐Yes ☐No	Hepatitis
☐Yes ☐No	Chest Pain/Angina	☐Yes ☐No	Jaundice
☐Yes ☐No	Arteriosclerosis	☐Yes ☐No	Liver Disease
☐Yes ☐No	Heart Attack	☐Yes ☐No	Thyroid Trouble
☐Yes ☐No	Swollen Ankles	☐Yes ☐No	Diabetes
☐Yes ☐No	Irregular Heart Beat	☐Yes ☐No	Kidney Trouble
☐Yes ☐No	Cardiac Pacemaker	☐Yes ☐No	Arthritis or Joint Disease
☐Yes ☐No	Heart Surgery	☐Yes ☐No	Stomach Ulcers
☐Yes ☐No	Stroke	☐Yes ☐No	Cancer
☐Yes ☐No	Epilepsy or Neurological Disorder	☐Yes ☐No	Radiation Therapy
☐Yes ☐No	Bronchitis	☐Yes ☐No	Chemotherapy
☐Yes ☐No	Chronic Cough	☐Yes ☐No	Contagious Diseases
☐Yes ☐No	Asthma	☐Yes ☐No	HIV/AIDS
☐Yes ☐No	Sinus Problems	☐Yes ☐No	Problems with Immune System
☐Yes ☐No	Snoring	☐Yes ☐No	Contact Lenses
☐Yes ☐No	Sleep Apnea	☐Yes ☐No	Eye Disease/Glaucoma
☐Yes ☐No	Difficulty breathing/Lung Problems	☐Yes ☐No	Pain and Clicking of Jaws
☐Yes ☐No	Tuberculosis	☐Yes ☐No	History of Drug/Alcohol Abuse
☐Yes ☐No	Emphysema/COPD	☐Yes ☐No	Depression
☐Yes ☐No	Do you smoke?	☐Yes ☐No	Anxiety
		☐Yes ☐No	Other _____

AUTHORIZATION

I certify that I have read and understand the questions above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I have made in the completion of this form. I authorize my dentist and his staff to complete an oral examination for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all radiographic imaging as required for my treatment.

Signature of patient (parent or guardian, if minor): _____ Date: _____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview regarding medical history:

_____

_____

_____

_____

_____

Doctor's Signature: _____ Date: _____

DENTAL HISTORY

Have you had or do you currently have:

☐Yes ☐No Sensitivity to hot, cold, or sweet?
Where? UR LR UL LL

☐Yes ☐No Headaches, ear aches, neck or jaw joint pain?

☐Yes ☐No Mouth ulcers?

☐Yes ☐No Cold sores?

☐Yes ☐No Broken teeth?

☐Yes ☐No Broken fillings?

☐Yes ☐No Clenching or grinding teeth?

☐Yes ☐No Bleeding, swollen, or irritated gums?

☐Yes ☐No Loose or shifting teeth?

☐Yes ☐No Bad breath?

☐Yes ☐No Dentures or partial dentures?

☐Yes ☐No Braces?

☐Yes ☐No Gum surgery or other treatments?

Please share the following dates:

Your last dental cleaning ____/____
Your last oral cancer screening ____/____
Your last set of complete dental x-rays ____/____
Name of previous dentist _____
City_____
Phone number _____
Why did you leave your previous dentist? _____
_____

If you could change your smile, would you:

☐Yes ☐No Make my teeth whiter

☐Yes ☐No Make my teeth straighter

☐Yes ☐No Close spaces between my teeth

☐Yes ☐No Replace metal fillings with tooth colored fillings

☐Yes ☐No Repair chipped teeth

☐Yes ☐No Replace missing teeth

☐Yes ☐No Replace old crowns that don't match

☐Yes ☐No Have a complete smile makeover

☐Yes ☐No If you could whiten your teeth for a cost anyone could afford, would you?

On a scale of 1-10, with 10 being the highest rating:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

What is the most important thing to you about your future smile and dental health?

_____
_____

What is the most important thing to you about your dental visit today?_____
_____

I prefer Burleson Smiles Dentistry to contact me in the following manner:

Leave contact number only at phone #_____

May leave brief message at phone #_____

May leave detailed message at phone #_____

Email_____

I authorize Burleson Smiles Dentistry to release information to the following persons:

Name_____ Relation_____ Phone#_____

Name_____ Relation_____ Phone #_____

Name_____ Relation_____ Phone #_____

Name_____ Relation_____ Phone #_____

I consent to Burleson Smiles Dentistry to share pertinent information for my dental health with the pharmacy of my choosing and specialists upon referral.

Yes_____

No_____

Signature_____ Date_____

Burleson Smiles Dentistry

Cancellation Policy

Please note Dr. Hawkins has reserved time specifically for your appointments. Failure to give 24 hours notice to cancel an appointment, or not showing up for an appointment may result in a $50.00 per scheduled hour fee to be assessed on your account. Additionally, if you are late for your appointment we may need to reschedule you for another day and you could be charged for a failed appointment.

_____ _____

Signature Date

Burleson Smiles Dentistry Financial Policy

We have several options available regarding services rendered here at Burleson Smiles Dentistry. We want you to understand these policies before any treatment is rendered. Please sign your initials by the options or options that best suit(s) your needs.

__1. Payment in FULL prior to start of treatment

__2. Dental Insurance Benefits.

As a courtesy, we are happy to file your dental insurance claim for you. However, each contract varies pertaining to what is covered for a particular group. We cannot predict exactly what your insurance will pay regarding your care. Please understand that your insurance policy is a contract between your insurance company and you. On the day services are rendered, you are required to pay your estimated patient portion, and we will file the remaining amount with your insurance company. Any outstanding balances not covered by insurance will be your responsibility to pay.

__3. Third-Party Financing

We also offer third-party financing through Care Credit, Wells Fargo health Advantage, and Lending Tree. They offer payment plans that offer both interest and deferred interest financing.

__4. Other Forms of Payment

We accept personal checks, cashier's checks, cash, money orders, MasterCard, Visa, American Express, Discover, and debit cards. If you would like, you can leave a valid credit or debit card on file with us. This is optional.

Name on card_____ CC#____-____-____-____ Exp:_____CVC____

By signing below, I have read and understand the financial policy. I understand that any outstanding balances not paid by insurance are my responsibility.

Signature_____ Date_____