Patient's name: _____ Date of Birth: _____ Sex: ❑ **M** ❑ **F**

Is this a minor? ❑ **yes** ❑ **no** Name of Responsible Party:_____

SSN # of Responsible Party:_____ Relation to Patient: ❑ **Parent** ❑ **Legal Guardian**

Primary Phone #:_____ ❑ **Cell** ❑ **Home** Other #:_____ ❑ **Cell** ❑ **Work**

Mailing address:_____ City/State/Zip Code: _____

Email: _____ How did you hear about us? _____

Emergency Contact Name & Number: _____

INSURANCE INFORMATION: Do you have Dental Insurance ❑ **yes** ❑ **no** **SSN of Subscriber:** _____

Policy Holder Name:_____ Date of Birth:_____ Employer: _____

Member ID#:_____ Group #: _____ Is this the Primary Ins. ❑ **yes** ❑ **no**

Insurance Name:_____ Phone #:_____ Claims Address:_____

Do You Have a Secondary Insurance ❑ **yes** ❑ **no** _____

MEDICAL HEALTH HISTORY Do you have, or have you had any of the following? (Please check any that apply):

Are you required to Pre-medicate before any dental treatment?
❑ **yes** ❑ **no**

- ❑ Blood Problems (Anemia)
- ❑ Blood transfusion
- ❑ Heart problems
- ❑ Heart murmur, mitral valve prolapse, heart defect
- ❑ Heart Pacemaker
- ❑ Stroke
- ❑ Bone or joint problems
- ❑ Artificial joint or valves
- ❑ High or low blood pressure (circle one)
- ❑ Tuberculosis or other lung problems
- ❑ Kidney disease
- ❑ Hepatitis, jaundice or other liver disease
- ❑ Diabetes TYPE 1 or TYPE 2 (circle one)
- ❑ Epilepsy or Neurological disorders
- ❑ Thyroid problems
- ❑ Arthritis
- ❑ Herpes or cold sores
- ❑ AIDS or HIV positive
- ❑ Cancer/Tumor
- ❑ Abnormal bleeding after any surgery (heavy bleeder)
- ❑ Hayfever or sinus trouble
- ❑ Allergies
- ❑ Asthma

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:_____

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners e.g. Coumadin)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin other diabetes drugs
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Natural supplements
- ❑ Other:_____

Women:

- ❑ Are your pregnant or planning to become pregnant
- ❑ Taking hormones or contraceptives

Do you smoke, vape or use tobacco?
❑ **yes** ❑ **no**

Name & Phone # of your primary medical physician:

_____

_____

When was your last dental visit?

_____

What brings you into our office today?

_____

_____

Signature of patient (or legal guardian) _____ Date _____

Thank you for choosing our office to assist you with your dental needs.

Patient Name: _____ *Date of Birth:* _____

No show, missed appointment office policy:

When our office books your appointment, we are setting aside a dedicated chair and time slot just for you. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

There is a charge of $30.00 per hour for not showing up for scheduled appointments.

*Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We, of course, would appreciate the same courtesy from you.

Responsible party office policy:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the Practice at the time services are rendered and that health, dental and accident insurance policies are an arrangement between my insurance carrier and me.

I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage only). I understand that while the Practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the Practice cannot verify insurance benefits eligibility for me or the patient prior to the treatment that I will pay in full for the services at the time they are rendered.

I understand that the Practice may charge: 1) a late fee of $25.00 per statement if payment on my account is not received by the due date on the statement sent to me; 2) an amount equal to $35.00, but not to exceed the maximum amount permitted by law for each returned check, and 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice will be charged $30.00 per hour 4) if I agree to an in-house financing option – then I agree to make sure that the payment will clear on the credit card I put on file or I will be charged $30.00 fee per transaction when it does not clear (not to exceed twice in a one month period).

I agree to the extent permitted by law, that if my account balance is referred to any agency or attorney(s) for collection purposes, to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable.

Acknowledgement of receipt of Notice of Privacy Practices:

By initialing above and signing below, I am acknowledging that:

I am either the patient or the patient's personal representative; I have received a copy of the "Notice of Privacy Practices" for Prairie Star Dental; and I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

Signature of patient, or parent or responsible party: _____

Description of relationship to patient: _____ Date: _____

Agreement to Receive Electronic Communication

Patient Name: _____ *Date of Birth:* _____

Is Patient a Minor? ❑ **yes** ❑ **no** **Legal Guardian/Representative Name:**_____

(Initial one) I _____ DO AGREE I_____ DO NOT AGREE

That the dental practice may communicate with me electronically at the email address and/or mobile phone number listed below.

Phone #:_____ Email:_____

I am aware that there is some level of risk that third parties might be able to read unencrypted emails. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

My most preferred method of electronic communication:

(Initial all that apply) _____Text Messaging _____ Email

I would like to receive: (check all that apply)

_____ Appointment Reminders/Recall Visits

_____ Information regarding insurance/billing

_____ Requests for Patient Satisfaction online reviews

I can withdraw my consent to electronic communications at any time by calling: Prairie Star Dental at 512-642-6104 or emailing info@prairiestardental.com

Patient or Legal Guardian Signature:_____ Date:_____

Dr. Thomas Rawcliffe, DDS
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Round Rock, TX 78665
info@prairiestardental.com