VILLAGE
Periodontics &
Implant Dentistry
972 966 2500 fax 972 471 9833

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:_____

SS#_____ Birthdate:_____

Address:_____ City:_____ St:_____ Zip:_____

Email Address:_____

Home Ph:_____ Cell:_____ Work:_____

Employer:_____ Who may we thank for referring you:_____

RESPONSIBLE PARTY INFORMATION

Relationship to Patient:_____

Last Name:_____ First Name:_____ MI:_____

SS#_____ Birthdate:_____

Address:_____ City:_____ St:_____ Zip:_____

Email:_____Employer:_____

Home Ph:_____ Cell:_____ Work:_____

Employer:_____

DENTAL INSURANCE INFORMATION (PRIMARY CARRIER)

Insured's Name:_____ Insurance Co.:_____

Ins. Co. Address:_____

Ins. Co. Phone #:_____ Insured's Employer:_____

Insured's SS# or ID#:_____ Group #:_____

The undersigned hereby authorizes Dr. Moore to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the patient's periodontal needs. I also assign all insurance benefits to Dr. Moore. Any payments received by Dr. Moore from my insurance coverage will be credited to my account, or refunded to me if I have paid the dental fees incurred.

PATIENT (or parent, if minor) SIGNATURE:_____
DATE:_____

E. Drew Moore, DDS, MS
2820 Village Pkwy, Suite 630
Highland Village, TX 75077
Office:972.966.2500

Medical History

1. Have you been under the care of a Physician during the past two years? __ Yes __ No
   If yes, for what? _____
   Physician's Name _____ Phone _____
   Address _____ City _____ State ___ ZIP _____
2. Have you taken any medication or drugs during the past two years? __ Yes __ No
3. Are you taking any medication, drugs or pills now? __ Yes __ No
   If yes, please list name and dosage _____
4. Have you ever taken prescription medication for weight loss (diet pills)? __ Yes __ No
   If yes, did you take any of the following: __ Yes __ No Fen-Phen (fenfluramine-Phenpermine)
   __ Yes __ No Pondimen (Fentluramine)
   __ Yes __ No Redux (Dexfenfluramine)
5. Are you aware of having an allergic (or adverse) reaction to any medication or substance? __ Yes __ No
6. Have you been a patient in the hospital during the past five years? __ Yes __ No
7. Indicate which of the following you have had, or have at present. Check "yes" or "no" to each item.

Heart (Surgery, disease, attack)	__ Yes	__ No	Ulcers	__ Yes	__ No
Chest Pain	__ Yes	__ No	Diabetes	__ Yes	__ No
Congenital Heart Disease	__ Yes	__ No	Thyroid Problems	__ Yes	__ No
Heart Murmur	__ Yes	__ No	Glaucoma	__ Yes	__ No
High Blood Pressure	__ Yes	__ No	Contact Lenses	__ Yes	__ No
Mitral Valve Prolapse	__ Yes	__ No	Emphysema	__ Yes	__ No
Artificial Heart Valve	__ Yes	__ No	Chronic Cough	__ Yes	__ No
Heart Pacemaker	__ Yes	__ No	Tuberculosis	__ Yes	__ No
Rheumatic Fever	__ Yes	__ No	Asthma	__ Yes	__ No
Arthritis/Rheumatism	__ Yes	__ No	Hay Fever	__ Yes	__ No
Cortisone Medicine	__ Yes	__ No	Latex Sensitivity	__ Yes	__ No
Swollen Ankles	__ Yes	__ No	Allergies or Hives	__ Yes	__ No
Stroke	__ Yes	__ No	Sinus Trouble	__ Yes	__ No
Diet (Special/Restriction)	__ Yes	__ No	Radiation Therapy	__ Yes	__ No
Artificial Joints (hip, knee)	__ Yes	__ No	Chemotherapy	__ Yes	__ No
Kidney Trouble	__ Yes	__ No	Tumors	__ Yes	__ No
Hepatitis A/B	__ Yes	__ No	Veneral Disease	__ Yes	__ No
A.I.D.S.	__ Yes	__ No	H.I.V. Positive	__ Yes	__ No
Cold Sores/Fever Blisters	__ Yes	__ No	Blood Transfusion	__ Yes	__ No
Hemophilia	__ Yes	__ No	Sickle Cell Disease	__ Yes	__ No
Bruise Easily	__ Yes	__ No	Liver Disease	__ Yes	__ No
Yellow Jaundice	__ Yes	__ No	Neurological Disorders	__ Yes	__ No
Epilepsy or Seizures	__ Yes	__ No	Fainting or Dizzy Spells	__ Yes	__ No
Nervous/Anxious	__ Yes	__ No	Psychiatric/Psychological	__ Yes	__ No

8. Do you use more than two pillows to sleep? __ Yes __ No
9. Have you lost or gained more than 10 pounds in the past year? __ Yes __ No
10. Do you have or have you had any disease, condition, or problem not listed? __ Yes __ No
11. Women: Pregnant? __ Yes: Months _____ __ No Nursing? __ Yes __ No
    Taking birth control pills? __ Yes __ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature _____ Date _____

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HIPAA ACKNOWLEDGMENT

Patient Name: _____

We are required by applicable federal and state law to maintain the privacy of your health information.

We are also required to give you notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice.

We use and disclose health information about you for treatment, payment and healthcare operations.

For example: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you; we may use and disclose your health information to obtain payment for services we provide assessment, evaluating practitioner/provider performance, conducting training programs, accreditation, appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes; we may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others; we may use and disclose your health information when we are required to do so by law.

In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us authorization, you may revoke it in writing at any time.

We will not use your health information for marketing communications.

Signature: _____ Date:

Relationship to Patient:

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FINANCIAL POLICY

Our primary goal is to provide patients with great dental treatment. We are in network with many insurance companies, this lowers the cost of your dental treatment and allows you to maximize your dental insurance benefits without compromising the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality materials we use, the time, effort and skill required in performing your dental treatment. We charge what is the usual and customary fee for our area and assist you with looking up your benefit eligibility before treatment. By doing this, we are able to give you the best **ESTIMATE** of your treatment cost.

Please review our office's payment options:

> **No Insurance:** Payment is due when services are rendered. We except cash, check, all major credit cards and offer Care Credit at 12 months interest free. A $25 return check fee will apply for all returned checks
>
> **Patients using dental insurance:** Your portion of the ESTIMATED treatment plan is due when services are rendered.
>
> **We file with all primary In-Network Insurance companies:** However in cases where insurance has denied a portion of your dental claim, you are responsible for the remaining amount, due at your next appointment or within 30 days from the denial.

We also realize that temporary financial situations may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account. Most often, financial misunderstandings can be managed with a phone call. Please feel free to contact our wonderful staff at anytime to discuss any concerns you may have.

DEPOSIT POLICY

Many procedures we do require us to order specific appliances and or parts for your specific treatment, ***30% of your patient portion will be due at date of scheduling and is NON REFUNDABLE.***

SEDATION POLICY

We offer the option of IV and "Non-IV Sedation" for treatment. ***When IV or Non-IV Sedation is used for your treatment, payment is rendered prior to appt***. Please feel free to speak with one of our staff members for more information on the IV or Non-IV sedation option to see if it's right for you.

I have read and agreed to the financial policy. I agree to a credit card on file that may be charged for violation of these policies or upon my approval for services rendered. If I fail to pay for those services, I agree to be responsible for all costs of collections, including reasonable attorney fees.

Signature of Patient or Responsible Party: _____
Date:_____

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Cancellation and No-Show Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office and not a dental "clinic." Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete, as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it.

If you do not show up for your appointment, Dr. Moore will not be able to see another patient in your time slot. Your time is valuable and Dr. Moore's time and that of his team, is also valuable.

Like many offices, this office does attempt to call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. Please be aware that if you arrive more than 15 minutes late to your scheduled appointment you may be asked to reschedule. There will be a charge of $50 for a broken appointments or cancellations if our office is not contacted by 12pm the day before your appointment.

If you have any questions regarding our late cancellation or no show policy feel free to ask! By signing this, you are aware and agreeing to the policy.

Signature _____ Date _____