2617 Thomas Ave.
Dallas, TX 75204
Ph. (214) 979-3278

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Name: ______________________________

I prefer to be called:______________ Male Female

Birth date: ____________ SSN:____________

Home address:__________________________

____

Hm # ____________ Cell #______________

Wk # ____________ Pgr # ______________

Email _________________________________

How do you prefer to confirm your appointments?

____

Employer: ______________________________

____

Occupation: ____________________________

Whom may we thank for referring you? __________

Other family members seen by us?

____

Previous / Present Dentist: _________________

Date of Last Visit : ________ Ph# ___________

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: ______________________

Address: ________________________________

Phone: _________________________________

Group # (Plan, Local, or Policy #) ______________

Insured's Name: __________________________

Relation: _______________________________

Insured's Birth date: _______________________

Insured's SSN: ___________________________

Secondary Dental Insurance

Insurance Co. Name: ______________________

Address: ________________________________

Phone: _________________________________

Group # (Plan, Local, or Policy #) ______________

Insured's Name: __________________________

Relation: _______________________________

Insured's Birth date: _______________________

Insured's SSN: ___________________________

In the event of an emergency, is there someone who lives near you that we should contact?

Name:_________________________________

Relation:_______________________________

Wk # ______________ Hm # ______________

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

Medical History

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain: ____

Are you taking any prescription/over the counter drugs? ☐ Yes ☐ No

If yes, please list: ____

Do you use or smoke tobacco in any form? ☐ Yes ☐ No

Have you or do you take Redux/Fen Phen or Pondimin? ☐ Yes ☐ No

For women: Are you taking birth control pills? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No week# _______

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

Y	N	Condition	Y	N	Condition
Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Arthritis	Y	N	Hospitalized Any Reason
Y	N	Artificial Bones/Joints/Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Latex Allergy
Y	N	Blood Transfusions	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Nervous/Anxious
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Problems
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any other serious medical condition(s) that you have ever had:

____

____

Are you allergic to any of the following items?

Y	N	Item	Y	N	Item
Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? ________________________

____

Many patients consult us for a 2nd opinion. Are you currently seeing another dentist for your dental needs? ☐ Yes ☐ No

If Yes, please explain: ________________________________

How would you describe the condition of your teeth and gums?
☐ Good ☐ Fair ☐ Poor

Are you currently in pain or discomfort with your teeth or gums?
☐ Yes ☐ No If yes, please explain:________________________

How often do you brush your teeth? _____________ Floss? ________

Do your gums bleed when you brush? ☐ Yes ☐ No

Do your gums bleed when you floss? ☐ Yes ☐ No

Have you ever experienced pain in you jaw joint? ☐ Yes ☐ No

Have you ever been treated for TMJ symptoms? ☐ Yes ☐ No

If yes, please explain: ________________________________

Do you grind or clench your teeth? ☐ Yes ☐ No

I understand that this information is correct to the best of my knowledge. I understand it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. I also give permission for the doctor or their staff to use any photos taken for lecturing, publishing, educational, or promotional purposes.

Signature ______________________ Date _______________

Patient portion is due in full at the time of treatment.

Financial Policy

Our fees are based on the quality of the materials we use, the time we spend with you, and our experience in performing your needed treatment. Our goal is not to let expense prevent you from benefiting from the quality of care you desire and need. To facilitate this goal we have developed the following financial options:

1. Major credit cards such as Visa, MasterCard and American Express.

2. CareCredit: CareCredit lets you begin your treatment immediately-then pay for it over time with low monthly payments that are easy to fit into your monthly budget. So, you can begin your dental care treatment today and conveniently pay low, monthly payments. Care Credit offers a full range of No Interest and Extended Payment Plans for treatment fees from $1 to over $25,000.
See our staff for more details on this program including interest free financing.

3. Insurance Assignment: As a courtesy to you, we will be glad to file your treatment with your insurance company. We will initially ask for your co-payment and estimated balance at the time of treatment. Please understand that this is only an estimate, and is based upon the information available to us. If for any reason, we have not received your insurance carrier's payment 30 days after the claim, the remaining balance will be due and payable by you.

Appointment Cancellation Policy/Late arrivals

At Dental House, appointments are made in advance by reserving the appropriate time slots to accommodate you, the patient, and your treatment to be performed. Our staff spends time meticulously preparing for each appointment by sterilizing, organizing and arranging the set up items prior to your arrival. This ensures that we achieve the high standard of care and treatment that we pride ourselves on. We, therefore, require at least **48 hours notice** prior to canceling. Patients who cancel their appointment without proper notice will be assessed a fee of **$95 for every hour of doctor scheduled treatment time and $35 for a one hour hygiene appointment. Arrival of 15 or more minutes after a scheduled hygiene appointment will result in rescheduling and a missed appointment fee of $35. Doctor restorative appointments of 3 or more hours will require a deposit.** This fee is for the amount of time and effort the staff has already spent preparing for the appointment.

We understand that unplanned events occur everyday. Should such an event occur, and a reasonable effort is made to contact our office to explain the situation, **no charges** will be assessed.

Assignment of Benefits and Release of Information

I hereby assign all medical/dental insurance benefits to which I am entitled to Mark R. Whitfield DDS, P.A., an out-of-network provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this statement is to be considered as valid as an original.

I hereby authorize Mark R. Whitfield DDS, P.A. to release any and all dental records and any other information which may be found within the records needed to secure payment or determine insurance benefits. This authorization shall remain valid until written notice is given by me revoking said authorization. I understand that I am responsible for all charges whether or not paid by said insurance.

I have read and understand the financial policy, assignment of benefits and authorization for release of information contained herein.

Patient ________________________________ Date ____________________________________

Patient HIPAA Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy by submitting your request in writing to Dr. Mark Whitfield.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

____ _______________
Signature Date

____
Witness

Optional: Please allow access to my personal health information (PHI) to:

____
Name Address Phone Number

____
Name Address Phone Number

Informed Consent for Initial Exam and Diagnostic Procedures

As part of your complete examination, we will look at and feel many of the structures of your head, neck, mouth, and teeth in order to evaluate their condition.

We will use a blunt probe under the gums next to your teeth to screen for the presence of gingivitis or periodontitis, gum diseases that can lead to tooth loss.

We will take a full set of up to X-rays in order to show us conditions that are not visible by looking or feeling. Recent original films of acceptable quality may substitute only if you can bring them with you. Where appropriate, we may supplement or substitute for the full mouth X-ray series with a "panoramic" X-ray which covers a broader area, and better relates oral structures to one another. We will use modern digital X-ray processes that can reduce your radiation exposure by up to 90%.

Depending on our other findings in these initial examinations, we may also require models or photographs to give us complete information. The models may be mounted on a jaw simulator to reproduce the chewing motion of your jaw.
Procedure costs without insurance.
Comprehensive Exam $102.00, FMX (full mouth x-rays) $153.00, Panorex X-ray $132.00, Preventative cleaning $111.00. Oral ID $10, Fluoride $20.00

Benefits, alternatives, and common risks:
Only with complete information can we develop an accurate diagnosis. There is no effective alternative to these diagnostic procedures. There are no substantial risks from these procedures, though occasional minor discomfort may be experienced by some patients. Risks associated with X-rays are always a concern, but modern equipment ensures a negligible exposure.

Consequences of not performing these procedures:
Inadequate diagnosis and/or refusal of x-rays may cause future pain, greater expense for later treatment, loss of teeth, and medical risk.
Every reasonable effort will be made to ensure that your diagnosis is completed properly, although it is not possible to guarantee perfect results. By signing below, you acknowledge that you have received adequate information about the proposed diagnostic procedures, that you understand this information, and that all of your questions have been answered fully. You also give permission for information gained from your examination to be used in clinical and economic research, practice marketing, and patient education activities and materials, provided that your identity is not reasonably discernible.

___ **I give my consent** for the proposed diagnostic procedures as described above.

___ **I refuse to give my consent** for the proposed diagnostic procedures as described above. I have been informed of the potential consequences of my decision to refuse complete diagnosis.

___ **I refuse diagnostic x-rays** and understand the risk of not having diagnostic x-rays.

Patient Signature and Date____

Witness Signature and Date_______________________________________