Patient Information Date: _____

Name: _____ S.S#: _____

Home Telephone: _____ Work Phone: _____

Cell Number: _____

E-mail: _____

Address: _____

City: _____ State: _____ Zip: _____

Birthdate: _____ Male: ___ Female: ___

Circle One: Married Widowed Single Divorced Separated Minor

Patient Employer/School_____

Occupation_____

Whom may we Thank for referring you?_____

In case of emergency who should be notified?_____ Phone _____

Responsible Party Information (if different than patient)

Person responsible for Account: _____

Relation to Patient: _____ Birthdate: _____

S.S#: _____ Cell Number: _____

Address (if different from pt.): _____

City: _____ State: _____ Zip: _____ E-mail: _____

Dental Insurance

Insurance Company: _____ Employer: _____

Subscriber Name: _____ DOB: _____ S.S#: _____

Plan #: _____ Subscriber #: _____ Group #: _____

Ins. Phone: _____

Drs. Brian & Amy Case
503 N. Nolan River Rd • Cleburne, TX 76033
(817) 517-6453
www.nolanriverdentalcenter.com

Section A: Acknowledgement of Receipt of Privacy Practices Notice. –
I, _____, acknowledge that I have received a Notice of Privacy Practices from the above name practice.
Signature: _____ Date:_____

If a representative signs this authorization on behalf of the individual, complete the following:
Representative's Name: _____
Relationship to Patient: _____

Information Release: I consent for my information to be given to only the following people:
Name: _____ Relation: _____
Name: _____ Relation: _____

Section B: Patient Consent for Medical Photography - I consent for medical photographs to be made of me or my child(or person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of diagnosis, referrals, medical teaching, or for publication in medical textbooks or journals.
Name:_____ Signature:_____

Financial Policy

- We accept cash, checks, or credit/debit cards.
- Payment for services is due at the time services are rendered unless prior arrangements have been made with the doctor and financial coordinator.
- Returned checks are subject to a $20 returned check fee.

Regarding insurance: Your insurance policy is a contract between you and the insurance company. We are not a party to that contract. In the event we do accept assignment of benefits and your insurance company has not paid your account in full within 60 days, the balance may be transferred to your account. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies' arbitrary determinations of usual and customary rates.

- All insurance co-pays and deductibles must be paid at the time of service.

We would be happy to discuss our charges and how they relate to your situation.

Missed Appointments

In order for us to serve you better, please allow 24 hours notice for rescheduling or cancelling appointments. ***If you fail to keep your appointment and/or cancel with less than 24 hour notice, you will be charged a $30 cancellation fee.***

Thank you for understanding our Financial Policy. Please let us know if you have any further questions.
I have read and agree to the Financial Policy.

Signature_____ Date _____

NOLAN RIVER DENTAL CENTER

Patient Name:_____ **DOB:**_____

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam_____
4. Are you now under a physician's care for a particular problem?.....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations?.....Y N
   If so, describe_____
6. Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?.....Y N

7. DO YOU HAVE OR HAVE YOU EVER HAD:

A. Rheumatic Fever or Rheumatic Heart Disease.....Y N
B. Congenital Heart Disease.....Y N
C. Cardiovascular Disease (**Circle all that apply:** Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery. Pacemaker.....Y N
D. Lung Disease (**Cirlce all that apply**: Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing).....Y N
E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness?.....Y N
F. Bleeding Disorder, Anemia, Bleeding Tendency, Blood Transfusion.....Y N
G. Do you bruise easily?.....Y N
H. Liver Disease?.....Y N
I. Kidney Disease?.....Y N
J. Thyroid Disease?.....Y N
K. Diabetes?.....Y N
L. HIV/AIDS?.....Y N
M. Hepatitis A, B, or C?.....Y N
N. Anxiety?.....Y N
O. Psychiatric Disorders?.....Y N
P. Arthritis?.....Y N
Q. Stomach Ulcers or Colitis?.....Y N
R. Glaucoma?.....Y N
S. Osteoporosis?.....Y N
T. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?.....Y N
U. Radiation (X-Ray) treatment for Cancer?.....Y N
V. Clicking or popping or jaw joint, pain near ear, difficulty opening mouth, grind or clench teeth?.....Y N
W. Sinus or Nasal problems?.....Y N
X. Any disease, drug or transplant operation operation that has depressed your immune system?.....Y N

8. ARE YOU USING ANY OF THE FOLLOWING (Check all that apply):

☐ Antibiotics
☐ Anticoagulants (Blood Thinners)
☐ Aspirin or drugs such as Motrin, Aleve or Ibuprofen
☐ High Blood Pressure medications
☐ Steroids (Cortisone, Prednisone, etc.)
☐ Insulin or Oral Anti-Diabetic drugs
☐ Digitals, Inderal, Nitroglycerin or other heart drug

A. Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa)? .....Y N
B. Have you ever been advised *not* to take a medication?.....Y N
C. Please list any and all medications taken, including prescription medications, diet drugs, over-the-counter medications, herbal or holistic remedies, vitamins or minerals:_____
_____

9. ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERESE REACTION TO (Check any that apply):

☐ Local Anesthesia (Novacaine, etc.)
☐ Penicillin or other antibiotics
☐ Sedatives, Barbiturates
☐ Aspirin or Ibuprofen
☐ Codeine or other pain killers
☐ Latex or Rubber products
☐ Metal of any kind
☐ Chemicals or jewelry (rash or sensitivity)
☐ Food Products
☐ Other allergies or reactions? Please list:
_____
_____

10. Do you smoke or chew Tobacco?.....Y N
11. Is there any past history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?
_____
12. Have you been diagnosed with Autism Spectrum Disorder or Sensory Processing Disorder?.....Y N
13. Have you had any serious problems associated with any previous dental treatment?.....Y N
14. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?
_____

15. FOR WOMEN ONLY:

A. Are you pregnant, or is there any chance you might be pregnant?.....Y N
B. Are you nursing?.....Y N

16. Preferred Pharmacy: _____

Patient Signature_____ Date:_____ Doctor Signature:_____

Dental History

Are you satisfied with your teeth and their appearance?

- Yes
- No

Please check any that may apply to you.

- Sensitivity (hot, cold, sweet)
- Tooth pain or discomfort
- Headaches, earaches, neck pain
- Jaw joint pain
- Teeth or fillings breaking
- Grinding or clenching teeth
- Bleeding, swollen, irritated gums
- Loose, tipped or shifting teeth
- Bad breath or bad taste in your mouth

Are you interested in whiter teeth?

- Yes
- No

If you have missing teeth, are you interested in replacement options?

- Yes
- No

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

Why did you leave your previous dentist?

_____

Is there anything that you would like us to know, so that we can better treat you?

_____