

The Art of Dentistry
Van E. Parham, DDS, PA
Family, Cosmetic and Orthodontic Dentistry
3100 N. O'Connor Rd., Suite 100
Irving, TX 75062
(972) 255-9000

PATIENT INFORMATION

Patient Legal Name _____ Preferred Name _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Ext. _____

Cell Phone _____ Driver's License # _____

Birth Date _____ Social Security # _____

Sex: M F Marital Status: Single Married Widowed Separated Divorced

E-mail Address _____

Patient Employed By _____ Occupation _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

In order to serve you better, please answer the following questions:

Do you prefer an AM or PM appoint? (Circle one) AM PM No Preference

Can you come in for an appointment on short notice? (Circle one) YES NO

If Patient is minor/child:

Parent/Guardian Name _____ Social Security # _____

Sex: M F Marital Status: Single Married Widowed Separated Divorced

Birth Date _____ Driver's License # _____ Cell phone _____

Parent/Guardian Employed By _____ Work Phone _____

If patient is a full-time student, Name of School/College _____ City _____

Dental Insurance or "Dental Assistance," as it should be called, is designed to help pay "part" of the cost of dental treatment. Your employer has made this coverage available to you and we will do our best to help you maximize its benefits.

Dental Insurance is NOT designed to pay all the cost of treatment, but rather to be a PARTIAL AID.

Your insurance contract is **BETWEEN YOU AND YOUR INSURANCE COMPANY**. The type of benefits in your coverage depend on what your employer has negotiated with his company and the amount of money you wish to pay in premiums.

If your insurance company has not paid the estimated portion within 45 days, the balance becomes **YOUR RESPONSIBILITY**. We file the insurance as a **COURTESY** to ALL of our patients, in hopes to aid our patients of the stress of insurance.

Signature of Patient or Responsible Party

Date

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	Describe or List
Are you under a physician's care now?	Yes	No	_____
Have you ever been hospitalized or had a major operation?	Yes	No	_____
Have you ever had a serious head or neck injury?	Yes	No	_____
Are you taking any medications, pills, or drugs?	Yes	No	_____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	_____
Are you on a special diet?	Yes	No	_____
Do you use tobacco?	Yes	No	_____
Do you use controlled substances?	Yes	No	_____
Have you ever had BOTOX or DERMAL FILLERS?	Yes	No	_____

Women: Are you Pregnant/Trying to get pregnant? Nursing? Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other_____

Check if you have or have had any of the following:

AIDS/HIV Positive	Chest Pains	Frequent Headaches	Irregular Heartbeat	Scarlet Fever
Alzheimer's Disease	ColdSores/FeverBlisters	Genital Herpes	Kidney Problems	Shingles
Anaphylaxis	CongenitalHeartDisorder	Glaucoma	Leukemia	Sickle Cell Disease
Anemia	Convulsions	Hay Fever	Liver Disease	Sinus Trouble
Angina	Cortisone Medicine	Heart Attack/Failure	Low Blood Pressure	Spina Bifida
Arthritis/Gout	Diabetes	Heart Murmur*	Lung Disease	Stomach/Intestinal Disease
Artificial heart Valve*	Drug Addiction	Heart Pace Maker*	Mitral Valve Prolapse*	Stroke
Artificial Joint*	Easily Winded	Heart Trouble/Disease	Pain in Jaw Joints	Swelling of Limbs
Asthma	Emphysema	Hemophilia	Parathyroid Disease	Thyroid Disease
Blood Disease	Epilepsy or Seizures	Hepatitis A	Psychiatric Care	Tonsillitis
Blood Transfusion	Excessive Bleeding	Hepatitis B or C	Radiation Treatments	Tuberculosis
Breathing Problem	Excessive Thirst	Herpes	Recent weight Loss	Tumors or Growths
Bruise Easily	Fainting Spells/Dizziness	High Blood Pressure	Renal Dialysis	Ulcers
Cancer	Frequent Cough	Hives or Rash	Rheumatic Fever*	Venereal Disease
Chemotherapy	Frequent Diarrhea	Hypoglycemia	Rheumatism	Yellow Jaundice

Have you ever had any serious illness not listed above? Yes No

We only need the following information if we need to request x-rays or information:

Former Dentist _____
Address and/or phone number _____

Date of last dental care _____ Date of last dental X-rays _____

In case of Medical Emergency:

Physician's Name _____ Date of last visit _____

I Certify that I have read and understand the above information. To the best of my knowledge, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Signature of Patient or responsible Party

Date

The Art of Dentistry
Van E. Parham, Jr., D.D.S., P.A.
Family, Cosmetic and Orthodontic Dentistry
3100 N. O'Connor Rd., Suite 100
Irving, TX 75061
(972) 255-9000

Our Financial Alliance

We at Dr. Parham's office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care as cost-effective as possible. Please understand that payment of your bill is considered a part of your treatment.

YOUR ESTIMATED SHARE OF THE CHARGES ARE DUE AT THE TIME OF SERVICE.

- WE ACCEPT CASH, CHECKS, MONEY ORDERS, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER.
- CARE CREDIT- FINANCING PLAN WE OFFER AS A SEPARATE LINE OF CREDIT WHICH OFFERS FLEXIBLE FINANCING OPTIONS WITH APPROVED CARE CREDIT. UP TO 12 MONTHS NO-INTEREST.
(We would be more than happy to give you the application)

Please initial the following:

_____ I understand dentistry is not an exact science and no specific results can be assured or guaranteed. I understand treatment plan and fees proposed are subject to modification, depending upon unforeseen or undiagnosed conditions that may be recognized only during the course of treatment. I understand that any associated laboratory fees are my financial responsibility.

_____ We understand how valuable your time is and we will do everything possible to keep on track and make sure you are seen in a timely manner. When we make an appointment we reserve time in our schedule just for you, and we ask that you do the same for us. Unless cancelled, at least 24 hours in advance, we reserve the right to charge for missed appointments at the rate of a normal office visit. Let's both try and mark time for each other when we are less likely to run into problems – meetings, birthdays, vacations, etc... Please help us serve you better by keeping scheduled appointments.

_____ HIPPA – As required by the Privacy Regulations, by signing below, I hereby acknowledge that I have received a current copy of this practice's "NOTICE OF PRIVACY PRACTICES". I also understand that this office may change their Notice of Privacy Practices and is not required to honor the terms of the original/previous version(s).

Please let us know if you have any questions or concerns before signing this agreement.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan. I agree that parents are responsible for all fees and services rendered for treatment of a minor/child. To the extent permitted under applicable law, I authorize release of any information relating to my dental services. I hereby authorize payment of the dental benefits to the treating dentist or dental practice. I have read and understand this Financial Protocol. I understand that in the unlikely situation that my account was turned over for collections or litigation – that I would be responsible for the associated costs that this process would entail.

Signature of Patient or Responsible Party

Date

Dental Health Information

Thank you for providing us with Important Information that will help us serve you better.

Are you having any discomfort?	Yes	No	Is the brightness of your teeth important to you?	Yes	No
Any sensitivity to hot, colds, sweets, chewing?	Yes	No	Do you smoke or use Tobacco in any form?	Yes	No
Does dental treatment make you nervous?	Yes	No	How many soft drinks or sweet drinks do you have daily?	_____	
Have you experienced any of the following problems?	If you could change anything about your teeth – Would you make them: (Answer Yes or No)				
Bleeding gums	Yes	No	Whiter	_____	
Bad Breath	Yes	No	Straighter	_____	
Soreness in jaw joint	Yes	No	Close Spaces	_____	
Grinding your teeth	Yes	No	Replace black fillings with Tooth colored ones	_____	
Snoring	Yes	No	Repair chipped teeth	_____	
On a scale of 1-10, with 10 being the highest rating:	Replace missing teeth _____				
How important is your dental health to you?	Replace old crowns or caps That don't match _____				
1 2 3 4 5 6 7 8 9 10	Have less gum showing _____				
Where would you rate your current dental health?	Be able to chew better _____				
1 2 3 4 5 6 7 8 9 10	Do you prefer to save your teeth? Yes No				
Where would you like your dental health to be?	Have you had any teeth removed? Yes No				
1 2 3 4 5 6 7 8 9 10	Has a dentist or hygienist ever made you feel Uncomfortable about your teeth or Homecare? Yes No				
Do you think your dental health effects Your overall health?	Yes	No	What can we do to avoid this?	_____	
How often do you get your teeth cleaned?	_____				
When was the last time you had an oral cancer exam?	_____				
	Date of your last cleaning: _____				
If there were a way to whiten your teeth for a reasonable investment, would you be interested?	_____				
What is the most important thing to you about your future smile and dental health?	_____				
What is the most important thing about your dental visit today?	_____				