Whitley Family Dental

info@billwhitleydds.com www.billwhitleydds.com

1152 N. Buckner Blvd. | Suite H100A • Dallas, TX 75218 (214)320-9679

Patient Information

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

I prefer to be contacted by

☐ Cell Phone ☐ Text ☐ Email ☐ Home Phone ☐ Leave a message

Whom may we thank for referring you to our practice?

Referral Name: _____

In an emergency, who should be notified? Please enter name, phone number and relationship below

_____

_____

Responsible Party Information

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to Responsible Party

☐ Self ☐ Spouse ☐ Child ☐ Other

Primary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insurance Phone # _____

Insurance Authorization

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Dental Health Information

How would you rate the condition of your mouth?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

Previous Dentist Name and Phone Number

_____

_____

Approximate date of most recent dental exam, dental cleaning, and/or dental x-rays: *

_____

_____

I routinely see a dentist every

◯ 3 mos ◯ 4 mos ◯ 6 mos ◯ 12 mos ◯ Not routinely

What is your immediate concern about your dental health?

Check all that apply *

- [ ] Currently in pain/discomfort
- [ ] Complications from past dental treatment
- [ ] Trouble getting numb
- [ ] Any reactions to local anesthetic
- [ ] Had/Have braces or orthodontic treatment
- [ ] Experiences dry mouth
- [ ] Sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- [ ] Food gets trapped between any teeth
- [ ] Popping and/or clicking of your jaw joint
- [ ] Difficulty chewing
- [ ] Clenching or grinding of teeth
- [ ] Gums bleed when brushing or flossing
- [ ] Diagnosed with and/or treated for gum disease
- [ ] Bone loss around your teeth
- [ ] Unpleasant taste or odor in your mouth
- [ ] Gum recession
- [ ] Teeth become loose on their own (without injury)
- [ ] Burning sensation in your mouth
- [ ] Snores or wakes up frequently during the night
- [ ] Wisdom teeth removal
- [ ] None

If any of the checked boxes need further explanation, please describe:

Consent for Dental Services

I give consent to receive dental treatment deemed necessary by the Whitley Family Dental providers. Treatment procedures include, but are not limited to; examinations, oral prophylaxes (cleanings), fluoride treatments, sealants, restorations (amalgam/composite fillings and crowns), periodontal gum treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries risks including, but not limited to, swelling, bruising, allergic reaction, changes in pain perception, prolonged anesthesia, and/or permanent nerve damage.

I give consent to take x-rays, study models, review photographs, or any other diagnostic aids deemed appropriate by the Whitley Family Dental providers to make a thorough diagnosis of my dental needs.

This consent shall be considered in effect until rescinded or revoked.

- [ ] * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Consent for Financial Obligation

This agreement is to inform you of your financial obligation to our practice. All charges you incur for any treatment that is provided are your responsibility regardless of your insurance coverage. We will always recommend treatment based upon your dental needs, not based on insurance coverage which can be inadequate with some dental plans. Your estimated co-payment/deductible may be adjusted after the time of treatment depending upon the final reconciliation of insurance payments. Third party extended payment financing is available upon request and approval. Returned checks and balances older than 90 days will be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually). Our practice will accept an assignment of benefits from your insurance company and it is important to understand that the agreement regarding your dental benefits is between you, your employer, and your insurance company. Although we are willing to submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. Our practice does not guarantee that your insurance company will assist with payment for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount at that time. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation for your use in the dispute. It is your responsibility to resolve any type of dispute over payment made or not made by your insurance company to our practice.

Cancellations and Rescheduling Dental Appointments
Our office requires 24 business hours' notice to cancel or reschedule existing appointments with us. If we do not receive such notice, you may be subject to a charge of $100.00 for any missed appointment. If you have repeated missed appointments, a deposit of $100.00 for each patient appointment will be required prior to scheduling the next appointment.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ * **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Signature of patient, parent, or guardian completing this form:

Signature _____ **Date** _____

Relationship to patient *

☐ Self ☐ Parent ☐ Guardian ☐ Other

Response Date: _____