Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name *First Name* *Initial*

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ❑ M ❑ F Age _____ Birthdate _____ ❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name *First Name* *Initial*

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Pharmacy _____ Phone _____

Additional Insurance

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Address _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Please complete both sides.

Dental History

What would you like us to do today? _____ Are you in dental discomfort today? _____

Former Dentist _____ Address _____

Dentist's Email _____ Phone _____

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

Check (✓) yes or no if you have had problems with any of the following:

❑ Y ❑ N Bad breath
❑ Y ❑ N Bleeding gums
❑ Y ❑ N Clicking or popping jaw
❑ Y ❑ N Food collection between teeth
❑ Y ❑ N Grinding or clenching teeth
❑ Y ❑ N Loose teeth or broken fillings
❑ Y ❑ N Periodontal treatment
❑ Y ❑ N Sensitivity to cold
❑ Y ❑ N Sensitivity to hot
❑ Y ❑ N Sensitivity to sweets
❑ Y ❑ N Sensitivity when biting
❑ Y ❑ N Sores or growths in mouth

How often do you brush? _____ Floss? _____

How do you feel about the appearance of your teeth? _____ Do you wish your teeth were straighter? ❑ Y ❑ N

Do you wish your teeth were whiter? ❑ Y ❑ N Are you unhappy with any fillings, crowns or bridges? ❑ Y ❑ N

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❑ Y ❑ N

Other information about your dental health or previous treatment _____

Medical History

Physician's name _____ Phone _____

Date of last visit _____ Have you had any serious illnesses or operations? ❑ Y ❑ N

If yes, describe _____

Are you currently under physician care? ❑ Y ❑ N If yes, describe _____

Have you ever had a blood transfusion? ❑ Y ❑ N If yes, give approximate dates _____

Have you ever taken Fen-Phen/Redux? ❑ Y ❑ N

Have you ever used a bisphosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva. ❑ Y ❑ N

Do you smoke or use other tobacco/smokeless products? ❑ Y ❑ N Please circle all that apply: Cigarettes Cigars Vape Marijuana Chew Other _____

Women: Are you pregnant? ❑ Y ❑ N Nursing? ❑ Y ❑ N Taking birth control pills? ❑ Y ❑ N

Check (✓) yes or no whether you have had any of the following:

❑ Y ❑ N AIDS/HIV Positive
❑ Y ❑ N Anaphylaxis
❑ Y ❑ N Anemia
❑ Y ❑ N Arthritis, Rheumatism
❑ Y ❑ N Artificial heart valves
❑ Y ❑ N Artificial joints
❑ Y ❑ N Asthma
❑ Y ❑ N Atopic (allergy prone)
❑ Y ❑ N Back problems
❑ Y ❑ N Blood disease
❑ Y ❑ N Cancer
❑ Y ❑ N Chemical dependency
❑ Y ❑ N Chemotherapy
❑ Y ❑ N Circulatory problems
❑ Y ❑ N Cortisone treatments
❑ Y ❑ N Cough, persistent
❑ Y ❑ N Cough up blood
❑ Y ❑ N Diabetes
❑ Y ❑ N Epilepsy
❑ Y ❑ N Fainting
❑ Y ❑ N Food allergies
❑ Y ❑ N Glaucoma
❑ Y ❑ N Headaches
❑ Y ❑ N Heart murmur
❑ Y ❑ N Heart problems
Describe _____
❑ Y ❑ N Hemophilia/ Abnormal bleeding
❑ Y ❑ N Herpes
❑ Y ❑ N Hepatitis
❑ Y ❑ N High blood pressure
❑ Y ❑ N Jaw pain
❑ Y ❑ N Kidney disease or malfunction
❑ Y ❑ N Liver disease
❑ Y ❑ N Material allergies (**latex**, wool, metal, chemicals)
❑ Y ❑ N Mitral valve prolapse
❑ Y ❑ N Nervous problems
❑ Y ❑ N Pacemaker/ Heart surgery
❑ Y ❑ N Psychiatric care
❑ Y ❑ N Rapid weight gain or loss
❑ Y ❑ N Radiation treatment
❑ Y ❑ N Respiratory disease
❑ Y ❑ N Rheumatic/Scarlet fever
❑ Y ❑ N Shingles
❑ Y ❑ N Shortness of breath
❑ Y ❑ N Skin rash
❑ Y ❑ N Spina Bifida
❑ Y ❑ N Stroke
❑ Y ❑ N Surgical implant
❑ Y ❑ N Swelling of feet or ankles
❑ Y ❑ N Thyroid disease or malfunction
❑ Y ❑ N Tobacco habit
❑ Y ❑ N Tonsillitis
❑ Y ❑ N Tuberculosis
❑ Y ❑ N Ulcer/Colitis
❑ Y ❑ N Venereal disease

Are you currently taking any medications? If yes, list all:

_____

Do you have any drug allergies? If yes, list all:

_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this 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.

Signature _____ Date _____

Payment is due in full at time of treatment, unless prior arrangements have been approved.

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CONROE
ADVANCED
DENTISTRY

Patient Financial Agreement

We are honored you have chosen us for your dental care. Our goal is to provide the best dental care possible for you and your family in a relaxed and pleasant environment. In order to keep a completely professional and up-front relationship with our patients, we would like to inform you of our financial policies prior to your treatment.

FOR OUR PATIENTS WITH DENTAL INSURANCE:

Dr. Stephen Vargo is not a contracted dentist with any dental insurance plan, but we are happy to file benefits on your behalf. We will gladly verify your dental benefits and process your primary and secondary insurance claims with the following agreement:

- Your dental insurance is an agreement between you and your insurance company.
- All patient copayments and/or patient portions are only an estimate/never a guarantee of payment.
- As part of your contact with your insurance company, you are responsible for all out-of-pocket portions/copayments and deductibles.
- Insurance payments not paid after 90 days will become your complete responsibility and must be paid in full.

IF WE ARE NOT BILLING DENTAL INSURANCE:

- We offer a 3% cash/check discount for treatment paid in full at time of service.

PAYMENT OPTIONS:

- For your convenience, we accept Visa, Mastercard, Discover, Check, Money Order or Cash (exact change please).
- Care Credit, specializing in helping patients finance large dental or orthodontic cases. No down payment is required, and payments can be made up to 12 months with little to no interest rates.
- If you need any other financial arrangements, please ask **prior** to scheduling treatment.

In order to keep our fees as reasonable as possible, we ask our patients cooperation in keeping their reserved appointment as scheduled. Missed appointments not only delay necessary treatment but also keep other patients in need of dental care from receiving treatment.

We appreciate the opportunity to serve you and thank you for choosing us to take care of your dental needs.

Responsible Party Name	Signature	Date

CONROE
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DENTISTRY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA Privacy Rule states that health providers must also post in a clear and prominent location, and provide patients with, a written Notice of Privacy Policy.

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other that office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient record, and other documents or information.

2. Some information, such as HIV-related information, genetic information, alcohol, and/or substance use disorder treatment records, and mental health records may be entitled to special confidentiality protections under applicable state or federal laws. We will abide by these special protections as they pertain to applicable cases involving these types of records.

3. It is the policy of this office to remind patients of their appointments. We may do this by telephone, email, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

4. The practice utilizes a number of vendors in the conduct of business. These vendors may have access the patient history information but must agree to abide by the confidentiality rules of HIPAA.

5. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

6. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

7. Your information will not be used for the marketing purposes or advertising of products, goods, or services.

8. We agree to provide patients with access to their records in accordance with state and federal laws.

9. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Release Form and any subsequent changes in the office policy. I understand that this content shall remain in force from this time forward and will remain in effect until terminated by me in writing.

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____

Medical Information Release of Information

I hereby authorize that Conroe Advanced Dentistry may disclose my health information to and person(s) who accompany me to my appointments and are present with me in the office while I meet with my dentist and staff.

I hereby authorize that Conroe Advanced Dentistry may disclose my personal health information to the person I have listed as my emergency contact.

___**Information is not to be released to anyone**

Patient/Guardian Name: _____

Patient/Guardian Signature: _____ Date: _____