GENE PAYNE D.D.S., P.C.

5340 Beltline Rd. Dallas, TX 75254
Phone 972-387-0731-Fax 972-893-3495

Date: _____

Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____ E-Mail _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for this visit:
_____

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/Immune Disorders
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Anesthetics Allergies
- ☐ Arthritis
- ☐ Artificial Joints _____
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mental Disorders
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnancy** Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Sinus Problems
- ☐ Special Diet
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Sulfa Allergy
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy

OTHER:

- ☐ _____
- ☐ _____
- ☐ _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
  - Name of Physician: _____ Phone:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____
- Are you currently taking medications? Please list. _____
  _____
  _____
- Do you require antibiotic coverage prior to dental care due to heart problems or joint replacement? ☐ Yes ☐ No
- If not sure, please check with your physician.
- Are you happy with your smile? ☐ Yes ☐ No

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Address, and Phone Number: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name, Phone Number, and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.
To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any changes in my health, I will inform the office staff at the next appointment without fail.

I have read the above conditions of treatment, payment, and consent for services and agree to their content. I have also read the HIPPA Privacy Policies for this office and agree.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

IF YOU ARE UNABLE TO KEEP ANY OF YOUR SCHEDULED APPOINTMENTS, PLEASE CALL 24 HOURS IN ADVANCE TO AVOID PAYING A $50.00 BROKEN APPOINTMENT FEE. THANK YOU.

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ relative ☐ friend

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____