Date ________________________

PATIENT INFORMATION

Name ____ SS#____________________

DOB ____________ Preferred Name ______________________ ( ) Male ( ) Female

Address ____

City ____________________________________ State __________ Zip _____________

Home Phone____________________________ Work Phone _____________________

Cell Phone _____________________________ Occupation______________________

Email ____

Place of Employment____

Business Address ____

City ____________________________________ State __________ Zip _____________

Hobbies ____

Spouse (If Minor, Parent Name) ____

Spouse Employment ____

Occupation ____

Responsible Party: Insurance Information

Name ____ DOB ______________

Relationship to Patient ____

Drivers License # _______________________ SS# ________________________

Employer ____

Occupation ____

Insurance Company ____

Claims Address ____

Phone __________________________ Group Number ______________________

Whom may we thank for referring you? ___________________________________

Has anyone from your family been seen in our office? _________Yes ________No

Why did you choose Dr. Wyatt as your Dentist? ____________________________

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistant as he deems fit. I also understand that prior to treatment; full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I authorize that my records can be used by the doctor if he so determines. I consent to the making of videotapes, photographs, and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance with its credit terms and policy. I agree to pay for all services rendered by this office. I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

____

SIGNATURE OF RESPONSIBLE PARTY DATE

2717 Cross Timbers Rd. Ste 424 Flower Mound, Texas 75028
Phone (972) 355-2222 Fax (972) 355-3234
www.FlowerMoundDental.com

Medical History

Patient Name ____

Medical Doctor __________________________________ Phone_______________________

Most Recent Physical Examination ____________________ Purpose _____________________

What is your estimate of your general health? ____

Have you or anyone in your household had COVID-19? __________________________________

When? ___________ Are you, or have you had a fever in the last 24 to 48 hours? ______________

Have you or anyone in your household been out of the state or country in the last 7 to 14 days? Yes or No

If yes, please explain ____

****PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS, INCLUDING OVER THE COUNTER, YOU ARE TAKING.****

Have you ever been hospitalized for an illness or injury? Yes or No

Please List ____

Have you ever had an Allergic Reaction to Any Medications? Yes or No

Please List ____

Are you presently being treated for any illness? Yes or No

Please List ____

Are you aware of a change in your overall general health? Yes or No

Please List ____

Please **LIST** all medications you take ____

____

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HAVE YOU EVER HAD THE FOLLOWING?

	Y	N		Y	N		Y	N
Heart Problems			Glaucoma			Emotional Problems		
Heart Murmur			Contact Lens			Psychiatric Problems		
Rheumatic Fever			Head or Neck Injuries			Antidepressant Medication		
Scarlet Fever			Epilepsy, Convulsions, Seizures			Alcohol / Drug Dependency		
Abnormal Blood Pressure			Viral Infections & Cold Sores			Often Exhausted or Fatigued		
Stroke			Hives, Skin Rash, Hay Fever			Subject to Frequent Headaches		
Artificial Prosthesis (Heart Valve or Joints)			Hepatitis List Type _____			Considered a touchy Person		
Anemia or other Blood Disorder			HIV / AIDS			Often Unhappy or Depressed		
Prolonged bleeding due to slight cut			Tumor / Abnormal Growth			Easily Upset or Irritated		
Emphysema			Radiation Therapy			Stomach or Duodenal Ulcer		
Tuberculosis			Chemotherapy			Digestive Disorders		
Asthma			Thyroid or Parathyroid Disease			Arthritis		
Sinus Problems			Hormone Deficiency			Liver Disease		
Kidney Disease			High Cholesterol			Jaundice		
Diabetes			Any Lumps or Swelling in the Mouth			Venereal Disease		

Do you Smoke, Vape, or use Electronic Nicotine? Yes or No How Many Years? ________________

FEMALE: Taking Birth Control Pills? Yes or No Pregnant? Yes or No How Far Along?__________

MALE: Prostate Disorders? Yes or No Do you take ED medication? Yes or No

Please describe **ANY OTHER** medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. ____

____

Patient's Signature ____ Date ___________________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____

{Please Print Name}

____

{Signature}

____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

[ ] Individual refused to sign

[ ] Communications barriers prohibited obtaining the acknowledgement

[ ] An emergency prevented us from obtaining acknowledgement

[ ] Other (Please Specify)

____

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Patient Photo / Video Release Form

In our office, Dr. Wyatt, likes to photograph our patients to aid him in determining dental problems and solutions/treatment. We are very proud of the work we have done and only use our own patients in marketing and advertising. All the portraits in our office and on our website (www.flowermounddental.com) and in our ads are our own patients.

I hereby authorize Dr. Wyatt and / or any of his assignees to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising (including website publications, Facebook, YouTube, magazines, phone books, television), and professional publications (dental magazines and journals).

I further understand that if the photographs, slides, and / or videos are used in any publication or as a part of a demonstration, my name (First Name Only) or other identifying information could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these photographs.

Please initial:

_____I do not mind if my first name, face, and teeth are used in any of the above stated situations.

Patient Name ____

Patient/Guardian Signature____

Date___________________

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Financial Options for Our Patients

Flower Mound Dental wants all our patients to be able to comfortably afford their dental care. We proudly offer the following financial choices so our patients can have the opportunity to decide which payment option best suits their needs. If you have any questions, please ask. We are here to help!

Cash, Check, Credit Card. (*VISA, Master Card, Discover, American Express*) We are happy to offer a prepayment courtesy adjustment for all restorative treatment, if paid in full within five (5) working days from the day the patient schedules the appointment date. 5% with a Major Credit Card and the possibility of an additional 5% if paid in Cash or Check.

Outside Financing. We have several different finance companies to choose from that offer payment plans to patients with good standing credit. Payment terms range from 3 months to 60 months and require no down payment. Some of the plans Dr. Wyatt will pay are Interest Free up to 12 months while others have an interest charge that is typically less than half of personal credit cards. The application process can be completed within a few minutes right from your phone or from the privacy of the patients' home.

Insurance. Our office will gladly work with most insurance companies to help our patients get the maximum benefit available from their company. Most dental plans do not cover 100% of the cost of treatment. Because of this, we ask our patients to pay their deductible and estimated percentage on the day service is rendered. We will estimate as closely as possible, however, we can make no guarantee of any estimated or actual amounts.

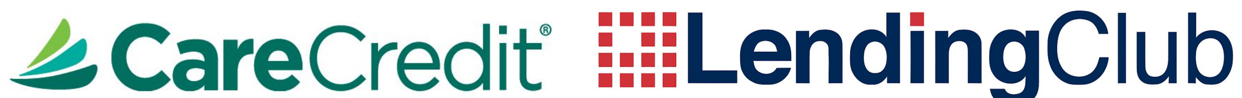
> *Note: Dental insurance coverage is a negotiated contractual agreement between your employer and the insurance company, but the ultimate responsibility for all charges lies with you. If, after 60 days, the insurance company has not paid the claim, you will be responsible for the total balance.*

Consent: I have read, understand and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself, or my dependents, is mine, due and payable at the time services are rendered.

Responsible Party Printed Name ____

Signature ____ Date ________________

No Interest Financing Options Available



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MISSED APPOINTMENT AND LATE CANCELLATION POLICY

A missed dental appointment presents problems for us both. For you, a missed dental appointment causes a delay in recommended treatment to help improve your health.

For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual times for each patient based on their need to allow us to deliver the quality and personal care every patient deserves.

Our office policy is that we charge $25.00 to $75.00 per hour for a missed appointment, late cancellation, or failed appointments. The charge is based on the length of time reserved for your appointment.

We understand things happen and schedules do change. We ask that you provide us with at least a 24-hour notice for any appointment changes as a courtesy to both of us. Failure to provide at least 24-hour notice changed appointment will result in a fee.

We value and appreciate you as a patient and look forward to seeing you for future appointments.

Patient Name (Please Print): ____

Parent / Guardian Name (Please Print): ______________________________________

Patient / Guardian Signature: _______________________________Date: __________

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