PATIENT ACQUAINTANCE FORM

Patient's Name_____ Male____ Female____
First Last
Mailing Address_____
City_____ State_____ Zip_____
Home Phone #_____Work #:_____
Other Number_____ E-Mail Address_____
Date of Birth _____S.S.Number_____
Employer's Name _____Address_____
Occupation_____
Spouse's Name_____ Employer_____ Work #_____

INSURANCE INFORMATION

Name of Insured _____ SS#_____ Date of Birth_____
Employer's Name_____ Address_____
Insurance Co's Name_____ Phone #_____Group#_____

METHOD OF PAYMENT

Check_____ Cash_____ Credit Card_____
Person Responsible for account_____

In Case of Emergency, Please Contact:
Name_____ Phone #_____
Relationship_____

Whom may we thank for referring you to our office?_____
Relationship_____

I understand that my insurance company may pay less than the actual bill for services and that I am fully responsible for payment of my account. By signing this statement I agree to pay for any and all services not paid, in whole or in part by my dental or medical insurance/ payor and any legal fees incurred to enforce this statement.
I hereby authorize the release of any information relating to insurance claims and I authorize payment of my group insurance benefits directly to Darshan P. Patel, DDS

I certify that the information I have provided here is true and correct.

Signature_____ Date_____

For information, concerns, or complaints about your dental care, contact:
State Board of Dental Examiners
333 Guadalupe, Tower 3, Suite 800
Austin, TX 78701 (512) 463-640

We are a health-centered dental practice, thus we are concerned with your total well being, not just your oral health. An essential part of our approach is a thorough health history. Please fill out the health questionnaire completely, even if some of the questions may not seem relevant to your dental health. THANK YOU !

MEDICAL HISTORY

Patient's Name_____ Date_____

1. Are you in good health? Yes No
2. Are you now under the care of a physician? Yes No
   Physician's Name_____ Phone #_____
3. Have you ever been hospitalized or had a serious illness? Yes No
   If yes, explain:_____
4. When was the last time you saw a physician?_____
   Reason_____
5. Are you allergic to or have you had any unusual reactions to any medications? Yes No
   If yes, please explain_____
6. Have you ever had an unusual skin reaction to jewelry or other metals? Yes No
7. Do you have an allergy or sensitivity to latex? Yes No
8. Are you taking any medications at this time? Yes No
   Please list;_____

9. Do you have or have you had any of the following? (please circle)

Heart Attack or Heart Trouble	Yes	No	Hay Fever / Allergies	Yes	No
Heart Murmur/ M.V.P.	Yes	No	Lung Problems	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No
High/ Low Blood Pressure	Yes	No	Kidney Problems	Yes	No
Circulatory Problems	Yes	No	Stomach Problems	Yes	No
Epilepsy/ Seizures	Yes	No	Digestive Problems	Yes	No
Anemia	Yes	No	Arthritis/ Rheumatism	Yes	No
Excessive Bleeding/Hemophilia	Yes	No	Thyroid Problems	Yes	No
Diabetes/ High Blood Sugar	Yes	No	Tumors/ Cancers	Yes	No
Hepatitis/ Jaundice	Yes	No	HIV/ AIDS Exposure	Yes	No
Blood Transfusion	Yes	No	Nervousness	Yes	No
Venereal Disease	Yes	No	Drug Addiction	Yes	No

10. Have you had surgery, x-ray or chemotherapy treatment for a tumor, growth or other condition of your head or neck? Yes No
11. Do you smoke cigarettes or use smokeless tobacco? (circle) Yes No
    How long?_____ Hovt much per day?_____
12. Do you drink alcoholic beverages? Yes No
    How much?_____
13. Are you employed in any situation which exposes you regularly to x-rays or other ionizing radiation? Yes No
14. Have you ever taken the diet drugs Fen-Phen or Redux? Yes No
15. Do you have any other disease, condition, or medical problem not listed Above that you think the Doctor should know about? Yes No
    If yes, explain_____

Women

16. Are you pregnant, or is there a possibility you might be pregnant? Yes No
    If yes, what month?_____
17. Are you nursing? Yes No

Please Turn Over

DENTAL HISTORY

1. What is the reason for your visit today?_____
2. When was the last time you saw your dentist?_____
3. What was done at that time?_____
4. Have you ever been treated for periodontal disease (gum disease)? Yes No
5. Have you had orthodontic treatment done (braces)? Yes No
6. Do you snore? Yes No
7. Does dental treatment make you nervous? Yes No
8. Have you ever had an unpleasant dental experience? Yes No
   If yes, explain_____
9. Do you experience any of the following?

Bleeding or sore gums	Yes	No	Loose teeth	Yes	No
Bad Breath/ unpleasant taste	Yes	No	Sensitive to hot	Yes	No
Frequent dry mouth	Yes	No	Sensitive to cold	Yes	No
Tingling or burning tongue/lips	Yes	No	Sensitive to sweets	Yes	No
Swelling or lumps in mouth	Yes	No	Clicking/ popping jaw	Yes	No
Sores in mouth	Yes	No	Frequent headaches	Yes	No
Food trapping between teeth	Yes	No	Grinding/ clenching	Yes	No

10. How often do you brush your teeth?_____
11. Do you use dental floss or tape?_____ How often?_____
12. What type of toothbrush do you use? (circle) Soft Medium Hard Electric
13. What other cleaning aids, devices, or rinses do you use?_____

SMILE EVALUATION

1. Are you self conscious when you smile in front of other people or pictures? Yes No
2. Do you ever cover your smile with your hand? Yes No
3. Do you wish your teeth were whiter? Yes No
4. Do you dislike the shape of your teeth? Yes No
5. Do you have spaces between your teeth that you don't like? Yes No
6. Do you have old fillings or dental work that you don't like looking at? Yes No
7. If you could wave a "magic wand" and change the appearance of your smile, how would you like it to look?_____

Please list any questions and concerns that you may have about your mouth or oral health:

_____

_____

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes in my medical status to my treating Doctor as soon as possible, and I agree to do so. I give permission to my treating Doctor to obtain from my physician information regarding my medical history, if needed, to provide me the best treatment possible.

I hereby authorize Darshan P. Patel, DDS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental needs

Patient's Signature_____ Date_____

Dentist's Signature_____

ESTHETIQUE DENTAL

Family and Cosmetic Dentistry

OFFICE POLICY

In an effort to keep health care costs down while maintaining a high level of professional care, we have established the following financial policies for payment of treatment.

1. Your co-payment is due in full at the time of treatment for each visit unless prior arrangements have been made with our Office Manager. We accept cash, checks, debit cards, Visa, MasterCard, Discover, and American Express.

2. We file your insurance as a courtesy. We do not assume responsibility if your insurance company does not pay on your filed claim.

3. We will accept payment from your insurance company. Current insurance information must be on file and updated at each visit. **THE PATIENT IS RESPONSIBLE FOR ANY NON-COVERED OR UNPAID INSURANCE BALANCE AFTER 30 DAYS FROM THE DATE OF TREATMENT**. Any treatment not paid by your insurance ***for any reason*** is your responsibility.

4. If unable to keep your appointment, please notify the office within 48 hours. Failure to do so will result in a ***broken appointment charge of $50.00***.

5. Any radiographs taken in the office are property of Esthetique Dental. There is a $25.00 fee for any duplication of x-rays.

6. There is a $35.00 service fee for returned checks.

I have read and I understand the above office policies and I agree to the terms.

_____ _____

Patient/ Guardian Signature Date