PATIENT INFORMATION

NAME____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐FEMALE
Last First M

SOCIAL SECURITY #_________________________ EMAIL_____________________________________

ADDRESS____
STREET APT# CITY STATE ZIP

DOB_____/_____/_____ TELEPHONE____
HOME WORK MOBILE

NAME OF EMPLOYER___________________________________ ADDRESS____________________________

IF FULL TIME STUDENT, SCHOOL NAME_________________________________ GRADE_________________

PERSON RESPONSIBLE FOR ACCOUNT- PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD- MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS- COMPLETE PRIMARY INSURED

PRIMARY INSURED/ RESPONSIBLE PARTY

NAME____ EMAIL__________________________
Last First M

TELEPHONE____
HOME WORK MOBILE

ADDRESS____
STREET APT# CITY STATE ZIP

NAME OF EMPLOYER___________________________________ INS CO.______________________________

SOCIAL SECURITY #__________________ SUBSCRIBER ID________________________ DOB_____/_____/_____

GROUP #__________________________ RELATIONSHIP TO PATIENT________________________________

PERSON TO CONTACT IN CASE OF EMERGENCY

NAME_________________________

ADDRESS_______________________

City/State/ZIP___________________

TELEPHONE #____________________

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic. Photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X________________________________
Patient or Responsible Party

____
Date State Driver's License #

Has any member of your family ever been treated in our office? ☐Yes ☐No

Whom may we thank for referring you to our office?
____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐Yes ☐No
☐Payment in full at each appointment (cash or personal check)
☐Payment in full at each appointment (☐VISA ☐MC ☐OTHER)
Card #_______________________ Exp. Date__________
☐I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE
If I do not pay the entire new balance within ______days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of ______% per month (or a charge of $______ for a balance under $______) which is an annual percentage rate of ______% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

TEXAS ★ STAR
DENTAL

MEDICAL AND DENTAL HISTORY

Today's Date:______________________________ Age:__________
Your Name:______________________________ Date of Birth:______________________
Physicians Name:___________________________ Physicians Phone #__________________
When was your last visit to your physician?______________________
When was you last complete physical?__________________________
Please list any ALLERGIES to Drugs, Medications or Anesthetics: _______________________________________
____

DO YOU HAVE A LATEX ALLERGY?____________
Please List all DRUGS/ MEDICATIONS you currently take: Include prescription and over-the-counter:_______
____
____

PLEASE TELL US IF YOU HAVE ANY OF THE FOLLOWING:

- ❑ Frequent Headaches
- ❑ Irregular Heartbeat
- ❑ High Blood Pressure
- ❑ Rheumatic Heart Disease
- ❑ Artificial Heart Valve(s)
- ❑ Mitral Valve Prolapse
- ❑ Heart Attack _______ Year
- ❑ Pacemaker
- ❑ Heart Murmur
- ❑ Arthritis
- ❑ Artificial Knee, Hip, Joint, Pins
- ❑ Stroke
- ❑ Abnormal Bleeding
- ❑ Glaucoma
- ❑ Fainting Spells
- ❑ Anemia
- ❑ Asthma
- ❑ HIV or AIDS
- ❑ Shortness of Breath
- ❑ Respiratory Disease
- ❑ Hay Fever
- ❑ Sinus Problems
- ❑ Shingles
- ❑ Tuberculosis/ TB
- ❑ Hemophilia
- ❑ Blood Transfusion
- ❑ Radiation Treatment
- ❑ Psychiatric Problems Chemical Dependency
- ❑ Diabetes
- ❑ Liver Problems
- ❑ Hepatitis
- ❑ Herpes
- ❑ Fever Blisters
- ❑ Ulcers/ Colitis
- ❑ Venereal Disease
- ❑ Thyroid Problems
- ❑ Cancer/ Tumors
- ❑ Epilepsy/ Seizures
- ❑ Kidney Problems
- ❑ Pregnant __ Months
- ❑ Other
  ____
  ____
  ____

Please describe the reason for your visit today: ____
____
When was your last dental check up? _____________________ Did you have x-rays taken?______________________
Who is your previous dentist?____________________________ May we request records?_________________________

PLEASE INDICATE IF YOU HAVE EVER NOTICED OR HAS ANY DENTIST OR HYGIENIST EVER SAID THAT YOU HAVE ANY OF THE FOLLOWING:

Have gum disease	_____	Lip or cheek biting	_____
Grind or clench your teeth	_____	Loose or broken fillings	_____
Clicking or popping jaw	_____	Had a "deep cleaning" in the past	_____
Jaw pain or tiredness	_____	Sores, blisters or growths	_____
Pain around ear	_____	Bad breath	_____
Dry mouth	_____	Bleeding gums	_____
Sensitivity to Hot/ Cold	_____	Sensitivity to sweets	_____

Do you use dental floss? _____ ______ How often? _________ times a day/ week.
How often do you brush? ___________ times a day.
Would you like whiter teeth? ________
Do you like the appearance of your smile? ____________
What would you change? ____
____
Have you ever been told that you require antibiotics before dental treatment? ______________
Do you have anxiety about dental treatment? __________ Rate on a scale 1-10 (10-highest) _____________
Patient Signature____________________________ Dr. Signature _____________________________________

TEXAS ★ STAR
DENTAL

CONFIDENTAL INFORMATION/ FINANCIAL GUIDELINE AGREEMENT

Please check below where you want to receive correspondences about appointments, billing and insurance inquiries, or dental healthcare questions.

Cell#______ Work#______ Home# ______ Other #______Email address______

May confidential; messages be left on the voicemail or Email given above? YES_______ NO________

If you do not have a voicemail, may a confidential message be left with a secretary, personal assistant or family member? YES________ NO________

Thank you for choosing our dental office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment.

PLEASE NOTE: Returned checks will be subject to an additional $30.00 fee. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

There will also be a $50 charge per hour if we do not receive a 48 hour cancellation notice.

Do you have Insurance?

- As a courtesy to you we help process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine that amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- Insurance payments are ordinarily received within 30 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received for your claim is denied, you will be responsible for paying the full amount at that time.
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with your insurance company over any claim.
- All emergency dental services, or any dental services performed without previous financial arrangements, must be paid at the time the services are performed unless arrangements are made.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.

I have read, understand and accept the terms of the above outlined guidelines for insurance handling and financial commitment that I may occur. After 60 days of the treatment date, I authorize Lauren Austin DDS to bill my credit card to pay any remaining balances left on may account.

Credit Card Type _________________ Credit Card Number ____

Expiration Date ___________________Security Code _____________________________

Signature of patient, or guardian (responsible party):

____ **Date**_____________________________

Informed Consent Photographs

I understand that photographs, x-rays and other records may be made during the course of my examination, treatment, and follow-up-care. I give permission for such items to be used for purposes of research, education, or publication on professional journals.

Signature ____

Date____________________________

CANCELLATION POLICY:

When you are scheduled for an appointment with our office, our dental team sets up and reserves a room specifically for your needs. While we understand that emergencies happen, we kindly ask that you please provide a **48-hour notice** if you need to cancel or reschedule any appointments.

Failure to provide a 48-hour notice will result in a fee of **$50 per hour** of scheduled appointment.

Thank you for understanding,

Texas Star Dental

Patient Printed Name: ____

Patient Signature: ____

Date: ________________________

CONSENT TO GIVE INFORMATION

I, ______________________, give permission to Lauren Austin and her employee/associates to give information to my parents/spouse regarding financial information and treatment needed. I am aware of my rights to privacy, HIPPA notice of privacy practice act of 1996, and release Dr. Austin and her employees/associates from any liability concerning the release of this information.

Signature ____ Date:_________________

Office Witness ____ Date:_________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

(You May Refuse to Sign This Acknowledgement)

I, _____________________________________, have reviewed a copy of this office's Notice of Privacy Practices.

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

______ Communication barriers prohibited obtaining the acknowledgement

______ An emergency situation prevented us from obtaining acknowledgement

______ Other (Please Specify)

____

____

____

Oral Screening Consent Form

Complete each time the examination is performed and place in the patient's file

Our practice continually looks for advances to ensure that we are providing the optimum level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. Tobacco and alcohol use are other major predisposing risk factors but **more than 25% of oral cancer victims have no such life style risk factors.** Studies also suggest that human papillomavirus (HPV) plays a roll in more than 20% of oral cancer causes. * Oral cancer risk by patient profile as follows:

Increased risk:	patients ages 18-39 -sexually active patients (HPV)
High risk:	patients age 40 and older; tobacco users (ages 18-39, any type within 10 years)
Highest risk:	patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use); previous history of oral cancer

We have recently incorporated VELscope powered by Sapphire into our oral screening standard of care. We find that using VELscope powered by Sapphire along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. VELscope Powered by Sapphire, along with the doctor's visual exam, is similar to proven early detection procedures for other cancers such as mammography, Pap smear, and PSA. VELscope powered by Sapphire is a simple and painless examination that gives the best chance to find any abnormalities at the earliest possible stage. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The VELscope powered by Sapphire exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-2007/08 procedure code D0431; however, this exam might not be covered by your insurance. The fee for this enhanced examination is ___$29.00___.

❒ Yes. I would prefer to have the VELscope powered by Sapphire exam at this time.

❒ No. I would prefer not to have the VELscope powered by Sapphire exam at this time.

Print Name ____

Signature ____ Date ______________________________

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TEXAS STAR DENTAL
SMILE EVALUATION

This is a simple questionnaire to help you obtain the smile you've always wanted. Hold a full face mirror 12-14" from your face. Smile to show your teeth. Take the time to observe your teeth carefully. Answer the following questions.

1. Do you like the appearance of your teeth and smile? ____ Yes ____ No
If not, explain____
____

2. Are your teeth all in alignment (straight)? ____ Yes ____ No
If not, explain____
____

3. Do you have spaces that you don't like? ____ Yes ____ No
If yes, explain____
____

4. Do you like the color of your teeth? ____ Yes ____ No
If not, explain____
____

5. Do you like the shape of your teeth? ____ Yes ____ No
If not, explain____
____

6. Are your teeth ____ Chipped ____ Protruding ____ Hidden?

7. Do you like the way your teeth come together? ____ Yes ____ No
If not, explain____
____

8 Are there old fillings or dental work that you don't like looking at? ____ Yes ____ No
If not, explain____
____

9. What would you like to change most in the appearance of your smile?
____
____

10. How would you like your smile to look?
____
____