MILANI DENTAL

1420 Schertz Pkwy Suite 210
Schertz, TX, 78154
P: (210) 651-5988 F: (210) 651-5988

Welcome

First Name:_____ MI:_____ Last:_____ Preferred Name:_____

Home Phone:_____ Work Phone: _____ Cell Phone:_____

DOB: _____ Male / Female SSN: _____

Address:_____ City:_____ State:_____ Zip:_____

Employer:_____

State ID/Driver's License #:_____ Email_____

Name of Physician:_____ Physicians Phone Number:_____ Last Exam:_____

Emergency Contact: _____ Relationship: _____ Phone Number_____

How did you hear about us?_____

Patient Health History

Do you have a history of?

- AIDS / HIV
- Alcoholism
- Allergies
- Anemia
- Arthritis
- Asthma
- Blood disease
- Bone disease
- Cancer
- Chemical dependency
- Chest pain
- Circulatory Problems
- Convulsions/seizures
- Diabetes
- Excessive bleeding
- Epilepsy
- Glaucoma
- Hay fever
- Head injuries
- Hearing impaired
- Heart disease
- Heart valve, murmur
- Hepatitis/ liver disease
- Hepatitis carrier
- High blood pressure
- Hip or joint replacement
- Hpv
- Jaundice
- Kidney Disease
- Kidney Dialysis
- Latex Sensitivity
- Lupus
- Low Blood Pressure
- Malignancies
- Mitral Valve Prolapse
- Neck and back problems
- Nervous problems
- Pacemaker
- Prosthetic joints
- Psychiatric care
- Radiation treatment
- Respiratory problems
- Rheumatic fever
- Rheumatism
- Scarlet Fever
- Sinus Problems
- Stomach ulcers
- Stroke
- Thyroid disease
- Tuberculosis
- Tumors or growths
- Ulcers
- Venereal Disease

PLEASE LIST MEDICATIONS BELOW:

_____
_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATIONS:

_____
_____
_____
_____

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Have you ever been hospitalized?
Y / N

_____
_____

Do you have any diseases/problems you think we should know about? **Y / N**

Have you had a transplant operation that has depressed your immune system? **Y / N**

_____
_____

FOR WOMEN ONLY:

Are you taking birth control pills? ___ Are you currently nursing or breastfeeding?___

Are you pregnant?___ Expected Due Date:_____ Possibility of Pregnancy? ___

NOTE: Antibiotics (such as penicillin) may alter the effect of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Patient Dental History

Date of last dental visit? _____

Name of your previous dentist_____

Reason for today's visit_____

Have you had an oral cancer screening? _____

How often do you floss your teeth? _____

Do your gums bleed when you brush? _____

Have you or a family member been treated for periodontal disease? _____

Have you ever had a popping or clicking near your ear when you chew? _____

Are you prone to frequent headaches? _____

Do you grind or clench your teeth? _____

Do you have sores, blisters or swelling on your gums lips or cheek? _____

Have you ever had orthodontic treatment? _____

Do you snore? Y / N

Do you have problems with bad breath? Y / N

Have you ever had an allergic reaction to a crown, metal filling or dental appliance? Y / N

Are your teeth Sensitive to hot, cold or pressure? Y/ N

If you could change something about your smile what would it be?

- Whiter
- Straighter
- Close space
- Replace black mercury filling with tooth color
- Repair chipped teeth
- Replace missing teeth
- Less gums showing
- Replace old crowns or caps that don't match

I Certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other members of his/her staff responsible for any errors that I have made in the completion of this form.

Patient/Guardian signature

_____

Date_____

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Payment Arrangement Form

Name of Patient:_____

Payment Agreement:

I agree that I am responsible for all services rendered to the Patient and that payment is due and payable to the practice at the time services are rendered and that health, dental and accidental insurance policies are an arrangement between my insurance carrier and me. I agree to pay all deductibles and co-pays at the time of service (if I have dual insurance coverage, my co-pay or deductible will be based on the primary coverage). I understand that while the practice will file claims with my insurance company on my behalf, I remain responsible to the Practice for what is not paid by my insurance company. I also understand that if the practice cannot verify insurance benefits eligibility for me prior to treatment that I will pay in full for the services at the time they are rendered. I understand that the practice may charge: 1) a late fee if payment on my account is not received by the due date 2) an amount equal to $35.00 but not to exceed the maximum amount permitted by law for each returned check. And 3) a fee for each appointment that is missed/canceled without at least 24 hours advance notice. I agree to the extent permitted by law that if my account balance is referred to an agency or attorney(s) for collection purposes to pay reasonable attorney's fees and any expenses or costs relating to the collection proceeding, including court costs. I understand that if treatment or care is suspended at any time by the patient, all fees for professional services rendered will be immediately due and payable. I authorize payment directly to the practice.

Responsible Party:

Full Name:_____ DOB _____ SSN#_____

Street Address: _____City_____ State_____ Zip_____

Home Phone: _____ Work Phone:_____

Employer Name:_____

Insurance Information:

Primary Insurance Name_____ Address_____ Phone Number_____

Name of Insured_____ Relationship_____ ID#_____ Group#_____

I acknowledge having received a copy of the practice's Notice of Privacy Practices. I agree that a photocopy of this authorization is as valid as the original.

Signature of Responsible Party: _____Date:_____

To be signed even if the patient is also responsible party

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Authorization for use or Disclosure of Protected Health Information

I hereby voluntarily authorize the disclosure of information from my health record. I understand that I may revoke this authorization at any time in writing and submitted to the Covered Entity above, except to the extend that action has been taken in reliance on this authorization.

_____
Name of the Patient

_____ _____
Signature of the Patient, Guardian or Legal Representative Date

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The information from my health record is to be disclosed by the Covered Entity above and provided to the following:

_____ _____
Name of person/organization Name of person/organization

_____ _____
Street Address Street Address

_____ _____
City/State/Zip City/State/Zip

The information to be disclosed from my health record is limited to (check):

- Only information related to: _____
- Only for the period from: _____ to _____
- Entire health record