Welcome *To our practice. Please take a few minutes to fill out this form as completely as you can. If you need help or have questions, we are glad to help you.*

Patient Information

Name_____ Sex ☐ M ☐ F Age _____ Birth date _____ ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mailing Address _____City, State, Zip_____

Physical Address_____ City, State, Zip _____

Email_____ Home Phone_____ Cell Phone_____ Work#_____

Driver's License_____ Soc. Sec# _____Patient Employed by _____

Occupation_____ Business Phone _____Notify in case of emergency & phone # _____

Whom may we thank for referring you? _____ Phone number _____
Are any of your family members patients in our office? _____ Relationship_____
I prefer to be contacted by (please circle) text, phone, at work or e-mail

Dental Insurance

Person Responsible for Account _____ Birthday _____ Soc. Sec # _____

Address if different from patient _____ Relationship to Patient _____

Home Phone (if different from pt) _____Cell Phone # _____

Employer _____ Occupation _____ Phone #_____

Insurance Co._____ Phone # _____ Email _____

Group # _____ Subscriber ID # _____

Name of other dependents under this plan _____

Other Dental Insurance

Person Responsible for Account _____ Birthday _____ Soc. Sec # _____

Address if different from patient _____ Relationship to Patient _____

Home Phone (if different from pt) _____Cell Phone # _____

Employer _____ Occupation _____ Phone #_____

Insurance Co._____ Phone # _____ Email _____

Group # _____ Subscriber ID # _____

Name of other dependents under this plan _____

I have reviewed the information above and it is accurate to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

Signature_____**Date**_____

Frisco's Dental Place

3535 Victory Group Way Ste.100 | Frisco, TX | (972) 827-8337

Financial Policy

Thank you for choosing Frisco's Dental Place. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa®, MasterCard®, American Express® or Discover Card®
- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card or Lending club

  Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Frisco's Dental Place requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

I authorize Frisco's Dental Place to call me on my cell/home phone to discuss my account and my insurance information.

Frisco's Dental Place $25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Frisco's Dental Place requires 48 hour notice for cancellations.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Informed Consent

☐ X-RAYS

Benefits:
More complete diagnosis
Can find hidden problems before they become big problems
Can make a determination of treatment
Possible Complications:
Exposure to x-ray radiation (minimal)
Consequences of not having work done or Postponing:
Cannot perform dental services
Increase risk of dental disease (pain & infection)
Alternatives:
None

☐ CLEANING & SCALING

Benefits:
Looks nicer
Clean Mouth
Eliminate odors
Prevent Gum Disease
Possible Complications:
Sensitive teeth
Filling may be loosened (normal if filling was ready to fall out)
Sensitive gums
Consequences of not having work done or postponing:
Stains on teeth
Odors
Gum disease
May lose teeth sooner
Alternative:
None

☐ LOCAL ANESTHETICS

Benefits:
Avoid pain during treatments and procedures
Possible Complications:
Gum sores
Prolonged numbness may extend beyond normal
Nerve damage
Bruising
In rare instances, possible consequences may include all those
applicable to general Anesthesia, including allergic reactions up to and including death
Consequences of not having work done or postponing:
Mild to severe pain during and after treatment
Alternatives:
Willingness to accept pain during treatment

I give my consent to perform the treatment selected above. I have been informed and understand the Benefits, Complications, Consequences and Alternatives to procedures recommended.
This Consent will remain in effect for all future appointments unless revoked by patient.

_____ _____
Patient or Parent Signature if minor Date

_____ _____
Print Patient Name Witness for Dr. Hunt

Confidential Health History

Patient Name _____ Date of Birth _____Date_____

1. CIRCLE APPROPRIATE ANSWER: (Leave blank if you do not understand the question)

1. Yes No Is your general health good? If no, explain _____
2. Yes No Has there been a change in your health within the last year? If yes, explain _____
3. Yes No Have you gone to the hospital or emergency room or had a serious illness in the last three years? If yes, explain _____
4. Yes No Are you being treated by a physician now? If yes, explain _____
   Date of last medical exam _____ Reason for exam _____
5. Yes No Have you had problems with prior dental treatment? If yes, explain _____
   _____
6. Yes No Are you in pain now? If yes, explain _____

2. HAVE YOU EXPERIENCED ANY OF THE FOLLOWING WITHIN THE LAST SIX MONTHS? (Please Circle)

Yes	No	Chest pain	Yes	No	Blood in stools	Yes	No	Frequent vomiting
Yes	No	Fainting spells	Yes	No	Diarrhea or Constipation	Yes	No	Jaundice
Yes	No	Recent significant weight loss	Yes	No	Frequent urination	Yes	No	Dry mouth
Yes	No	Fever	Yes	No	Difficulty urinating	Yes	No	Excessive thirst
Yes	No	Night Sweats	Yes	No	Ringing in ears	Yes	No	Swollen ankles
Yes	No	Persistent Cough	Yes	No	Headaches	Yes	No	Joint pain
Yes	No	Coughing up blood	Yes	No	Dizziness	Yes	No	Joint Stiffness
Yes	No	Bleeding Problems	Yes	No	Blurred Vision	Yes	No	Shortness of Breath
Yes	No	Blood in urine	Yes	No	Bruise easily	Yes	No	Sinus Problems
Yes	No	Difficulty swallowing						

3. HAVE YOU HAD OR DO YOU HAVE ANY OF THE FOLLOWING? (Please Circle)

Yes	No	Heart disease	Yes	No	AIDS/HIV	Yes	No	Psychiatric care
Yes	No	Family history of heart disease	Yes	No	Surgeries	Yes	No	Osteoporosis
Yes	No	Heart attack	Yes	No	Hospitalization	Yes	No	Thyroid disease
Yes	No	Artificial joint	Yes	No	Diabetes	Yes	No	Asthma
Yes	No	Stomach problems or ulcers	Yes	No	Family history of diabetes	Yes	No	Hepatitis
Yes	No	Heart defects	Yes	No	Tumors or cancer	Yes	No	Heart murmurs
Yes	No	Sexual transmitted disease	Yes	No	Chemotherapy	Yes	No	Herpes
Yes	No	Rheumatic fever	Yes	No	Radiation	Yes	No	Canker/cold sores
Yes	No	Skin disease	Yes	No	Arthritis, rheumatism	Yes	No	Anemia
Yes	No	Hardening of arteries	Yes	No	Emphysema	Yes	No	Other lung disease
Yes	No	Liver disease	Yes	No	High blood pressure	Yes	No	Eye disease
Yes	No	Seizures	Yes	No	Kidney or bladder disease	Yes	No	Transplants
Yes	No	Stroke	Yes	No	Tuberculosis	Yes	No	Cosmetic surgery
Yes	No	Eating disorders						

4. ARE YOU ALLERGIC TO OR HAVE YOU HAD A REACTION TO ANY OF THE FOLLOWING? (Please Circle)

Yes	No	Aspirin	Yes	No	Valium	Yes	No	Tetracycline
Yes	No	Darvon	Yes	No	Demerol	Yes	No	Vicodin
Yes	No	Codeine	Yes	No	Penicillin	Yes	No	Percodan
Yes	No	Local anesthetic	Yes	No	Latex	Yes	No	Food
		(Novacaine or Xylocaine)	Yes	No	Erythromycin	Yes	No	Metal
Yes	No	Nitrous oxide	Other:_____					

5. HAVE YOU TAKEN ANY OF THE FOLLOWING IN THE LAST THREE MONTHS?

Yes	No	Recreational drugs	Yes	No	Tobacco in any form	Yes	No	Antibiotics
Yes	No	Over-the-counter medicines	Yes	No	Alcohol	Yes	No	Supplements
Yes	No	Weight loss medications	Yes	No	Bisphosphonate (Fosamax)	Yes	No	Aspirin

Please List current medications:

_____

_____

6. WOMEN ONLY

Yes No Are you or could you be pregnant? If yes, what month?_____
Yes No Are you nursing?
Yes No Are you taking birth control pills?

7. ALL PATIENTS

Yes No Do you have or have you had any other diseases or medical problems **NOT** listed on this form?
_____
Yes No Have you ever been pre-medicated for dental treatment? If yes, why _____
Yes No Have you ever taken Fen-phen? If yes, when? _____

Yes No Is there any issue or condition that you would like to discuss with the dentist in private?

The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment.

I authorize the dentist to contact my physician.

Patient's Signature: _____ Date: _____

Physician's Name: _____ Phone Number: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication. Further, I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

_____
Patient Signature or Parent/Guardian if a minor Date Signature of Dentist Date

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MEDICAL UPDATES

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY New Medications or any new illness or new allergies	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Additional comments:_____
_____
_____
_____
_____
_____
_____
_____