WELCOME TO FENIX DENTAL
Trey Latiolais, DDS
1106 Broadnax
Daingerfield, TX 75638
903-645-7335
Fax-903-645-7336

Welcome to our office! To assist us in serving you, please complete the following confidential form. The information provided is important to your dental health.

Today's Date____________________

Patient's name____________________________________**Preferred name**________________________

Birth Date_________________________**Sex**______**Social security #**____________________________

If Minor, parents name____

Home Phone____________________**Cell Phone**___________________ **Work Phone**_______________

Email____

Mailing address________________________**City**_______________________**State**_____**Zip**_________

Billing Address (if different)_______________________**City**________________**State**_____**Zip**________

Employer/Occupation_________________________________**Is it okay to contact you at work?**______

Spouse's Name_____________________________**Phone**_____________________**Unmarried**________

Spouse's Employer____

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

Emergency Contact (other than spouse)____________________________**Phone**____________________

***I authorize my emergency contact/spouse to receive protective health information in the event that I am unable to be reached: yes/no**

Date_____**Patient Signature**__________________________**Contact's Relationship to patient**_________

BILLING, CREDIT AND INSURANCE INFORMATION ______**Not covered by dental insurance**

Dental Insurance CO____**Group number**_______________

Covered by spouse's insurance? ______**yes** ______**no**

Spouse's dental insurance company_______________________________**Group number**_____________

Spouse's birthday________________**Social Security number**___________________________

***I certify that the information provided is accurate and will be relied upon for granting credit and providing dental services. I understand that I am financially responsible for the charges not covered by or paid by my insurance for whatever reason.**

***I authorize payment directly to the dentist of any group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.**

X____
Signature of responsible party or patient (Parent if patient is a minor)

Date___________________

Patient Name____Date of Birth______________Age________

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following?
(please check any that apply)

- _____Cancer or tumor
- _____Radiation or chemo treatments
- _____Heart: ailment, angina, defect, murmur, Afib
- _____Heart: attack, stroke, bypass surgery, pacemaker
- _____Heart: stints, mitral valve prolapse
- _____ Rheumatic fever or rheumatic heart disease
- _____ Artificial joint(knee, hip shoulder, etc) or heart valve

Surgeon______________________Phone#___________________Date:________________________________

- _____High or low blood pressure
- _____Tuberculosis or other lung problems
- _____Kidney disease
- _____Hepatitis A/B/C or other liver disease
- _____Alcoholism/drug abuse
- _____Blood transfusion
- _____Diabetes Type I/II
- _____Neurologic condition
- _____Epilepsy, seizures, dizziness or fainting spells
- _____Emotional condition
- _____Arthritis
- _____Herpes or cold sores
- _____AIDS or HIV positive
- _____Migraine headaches or frequent headaches
- _____Anemia or blood disorder
- _____Abnormal bleeding after extractions, surgery or trauma
- _____Allergies, hay fever, sinus trouble or hives
- _____Intestinal problems
- _____Asthma
- _____Smoke or use tobacco products

Are you allergic to, or have you reacted adversely to any of the following?

- ______ Latex materials
- ______ Penicillin or other antibiotics
- ______Local anesthetics ("Novocain")
- ______Codeine or other narcotics
- ______Sulfa drugs
- ______Barbiturates, sedatives, sleeping pills
- ______Aspirin
- ______No known allergies

Other allergies___________________________

Are you taking any of the following?

- ______Aspirin
- ______Anticoagulants (blood thinners)
- ______Antibiotics or sulfa drugs
- ______High blood pressure medicine
- ______Antidepressants or tranquilizers
- ______Insulin, Orinase, or other diabetes drug
- ______Nitroglycerin
- ______Cortisone or other steroids
- ______Osteoporosis (bone density) medicine
- ______Other____________________________

____

WOMEN:

- ______May be pregnant
  - Expected delivery date:_____________
- ______Taking hormones or contraceptives

AIRWAY QUESTIONAIRE

Please answer the following questions to determine if you might be at risk of Obstructive Sleep Apnea:

Do you SNORE LOUDLY(loud enough to be heard through closed doors or your bed-partner elbows you for snoring at night)? YES or NO

Do you often feel TIRED, FATIGUED, or SLEEPY during the daytime(such as falling asleep while watching TV, during driving, or talking to someone)? YES or NO

Has anyone OBSERVED you STOP BREATHING or CHOKING/GASPING during your sleep? YES or NO

Are you older than 50? YES or NO

Check any that apply:

- ______CPAP intolerance
- ______Forgetfulness
- ______Insomnia
- ______Father or Mother has sleep apnea
- ______Previously diagnosed with Sleep Apnea
- ______Difficulty concentrating
- ______Morning headaches
- ______Father or Mother snores
- ______Obesity

Physician Name:____Phone Number:__________________________

Do you have any disease, condition, or problem not listed above? If yes, please specify_________________________

____

List any medications that you are currently taking:____

____

____

Signature of patient(or parent):____

Doctor's Signature:____

Date___________________

Patient Name____**Date of Birth**______________**Age**________

DENTAL HISTORY

Reason for visit? Main concern:____

Are there any conditions of which we should be aware?____

Previous dentist name and date of last appointment:____

Approximate date of last cleaning?______________**Approximate date of last x-rays?**_________________

Have you ever had gum(periodontal) treatment? If yes, when?____________________________________

Have you ever had prolonged bleeding after dental treatment? If yes, specify:_______________________

Have you had any problems from past dental treatment? If yes, specify:___________________________

Have you had problems with the effectiveness or bad reactions to dental anesthetic?_________________

How often do you brush?________________________**How often do you floss?**_______________________

What would you consider your biggest obstacle for completing any dental treatment?

______Time **______Money** **______Fear** **______Transportation**

Are you apprehensive about dental treatment?	**YES or NO**
Do you avoid brushing any part of your mouth because of pain?	**YES or NO**
Do your gums bleed easily?	**YES or NO**
Do your gums bleed when you floss?	**YES or NO**
Do your gums feel swollen or tender?	**YES or NO**
Are your teeth sensitive?	**YES or NO**
Are you dissatisfied with the appearance of your teeth?	**YES or NO**
Do you clench or grind your teeth?	**YES or NO**
Do you wake up with headaches or sore jaws?	**YES or NO**
Have you had any trauma to your head or neck?	**YES or NO**
Do you feel twinges of pain when your teeth come in contact with:	
Hot food or liquids?	**YES or NO**
Cold foods or liquids?	**YES or NO**
Sours?	**YES or NO**
Sweets?	**YES or NO**
If you are wearing a partial or denture:	
Are you satisfied with the appearance?	**YES or NO**
Are you satisfied with the comfort?	**YES or NO**
Are you satisfied with the chewing ability?	**YES or NO**

FENIX DENTAL
DR. TREY LATIOLAIS
1106 BROADNAX
DAINGERFIELD, TX 75638
903-645-7335

HIPPA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement and authorization
In refusing we will not be able to process your insurance claims, so you will be responsible for payment in full of all visits.

I understand that, under the Health Insurance Portability & Accountably Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

***Conduct, plan and direct my treatment and follow-up among the multiple healthcare provider who may be involved in that treatment directly and indirectly.**
***Obtain payment from third-party players.**
***Conduct normal healthcare operations such as quality assessments and physician certifications.**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the use and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

DATE:____

The undersigned acknowledges receipt of a copy of the currently effective *Notice of Privacy Practices* for this healthcare facility.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE IF I REQUIRE TESTING OR TREATMENT RESULTS BE SENT TO ANOTHER DOCTORE/FACILITY IN THE FUTURE.

____________________________________ ____________________________________
Please PRINT your name **Please SIGN your name**

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION: (This includes spouses and any care takers who can have access to this patient's records:
NAME______________________PHONE#________________RELATIONSHIP____________
NAME______________________PHONE#________________RELATIONSHIP____________

I AUTHORIZE CONTACT FROM THIS OFFICE TO *CONFIRM MY APPOINTMENTS, TREATMENT, BILLING INFORMATION, HEALTH INFORMATION VIA:*

_____CELL PHONE **_____HOME PHONE** **_____WORK PHONE**
#_______________ **#_______________** **#_______________**

FENIX DENTAL—1106 BROADNAX—DAINGERFIELD, TX—75638

Patient Name:___________________________________DATE of BIRTH____/____/___

Social Security #:_________________________Employer:________________________

Dental Insurance Carrier:____

ID#__________________________________GROUP#_________________________

If patient is under the age of 18, name of individual who is financially responsible for Patient:

NAME:____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the *<u>PATIENT'S RESPONSIBILITY</u>* to update Fenix Dental at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Fenix Dental. We do accept payments from the dental insurance companies; however, we are *<u>NOT</u>* contracted with them. It is a contract between you, your employer and the insurance company.

If requested, we will provide you with a verbal ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is *<u>your responsibility</u>*. While the filing of insurance claims is a courtesy that we extend to all our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with a payment from the insurance company, we will ask that you contact your carrier to rectify the problem. *<u>All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient/or account holder.</u>*

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. *<u>Any attorney or collections fees incurred due to delinquency in payment or collection efforts will also be charged to you including court costs and fees. Any personal checks returned unpaid or with non-sufficient funds (NSF) will incur a $30.00 NSF check fee and may also subject you to court costs and attorney fees.</u>*

We request a 48-hour cancellation notice for scheduled appointments. A cancellation fee of $75.00 may be charged if a 48-hour notice is not given.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

______________________________ ______________________________

Please PRINT your name **Please SIGN your name**

DATE:________________________