Sunrise Dental Linda Jacob, DDS

1150 N Watters Rd, #104, Allen TX 75013. Ph: 972-908-3773 Fax: 972-908-3776 eMail: info@sunrisedentalallen.com

Date:_____

Patient Information:

Last Name: _____ First : _____ Middle:_____

Date of Birth: _____ Age: _____ Gender: M / F Marital Status: _____

Home Phone: _____ Alternate Number: _____

Address: _____

City :_____ State : _____ Zip :_____

Social Security number: _____-_____-_____

Email: _____

Communication preference : Phone / PostCard / Email /Text (Pl circle one)

Responsible Party Information:

Last Name: _____ First : _____ Middle:_____

Date of Birth: _____ Age: _____ Gender: M / F

Marital Status: _____

Home Phone: _____ Alternative Number: _____

Address: _____

City :_____ State : _____ Zip :_____

Social Security number: _____-_____-_____

Driver License Number: _____

Relationship to Patient: _____

Employer: _____Occupation: _____No. of Years Employed_____

Name/Address/phone No. of Nearest relative not living with you: _____

_____

How did you hear about us? Please check below:

__ Sign ___Mail Coupon _____ Friend/Relative _____ Employer _____ Insurance Provider List

__Employee ___ Health fairs/ Screenings ___ News Paper __Yellow Pages

__ TV ad Which Station? _____ __ Radio Ad _____Which Station? _____ Bill Board

Other:_____

Reason for Todays dental Visit_____

Date of last dental visit_____ Reason_____

Previous Dental Treatments :_____

_____

Have you ever had an experience in a dental office that you would like to tell us about? YES /NO

_____

_____

Are you apprehensive about dental treatment? YES / NO

Are your teeth sensitive to hot, cold, sweets, pressure? YES / NO

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Do your gums bleed, feel tender or irritated? YES/ NO
Do you have discolored teeth that bother you? YES/ NO
Are you unhappy with the appearance of your teeth? YES/ NO
Are you now seeing a physician (s) is? YES/ NO
If so, what is the condition being treated? _____
The name & address of my physician (s) is? _____
What medications are you taking now? _____
_____
If female, are you pregnant? YES/ NO If yes, how long? _____

Mark any of the following which you have present or had:

__Heart Disease __Heart Pacemaker __Ulcers __Thyroid Disease
__Glaucoma __High Blood Pressure __Diabetes __Emphysema
__Chemo (Cancer, Leukemia) __Pain in Jaw Joints __Blood Disease __ Scarlet Fever
__Tuberculosis __Arthritis __HIV+ __Rheumatic Fever
__Anemia __ Asthma __ Rheumatism __ Hepatitis
__ Heart Mummer __Kidney Trouble __Hay Fever __Cortisone Medicine
__ Hemophilia __Venereal Disease __Epilepsy or Seizures __ Nervousness
__Other :_____ _____ _____

Mark any of the following medications you are allergic to:

__ Local Anesthetics __ Penicillin or other Antibiotic __ Sulfa Drugs __Aspirin
__Codeine or other narcotics __ Barbiturates, Sedatives, or sleeping pills __Iodine
__Other_____

To the best if my knowledge, all of the preceding answers are true and correct. If ever have any change in my health, or if any medicines change I will inform my dentist at the next appointment.

_____ _____
Date Signature of Patient/ Parent/ Guardian
----------Office use only----------

Medical History Updated:

Dr._____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

DR. LINDA JACOB, DDS

* You May Refuse to Sign This Acknowledgment*

I have received a copy of this office's Notice of Privacy Practices.

Print Name:_____

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

_____

_____

_____

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Office Consent for Services

(Pl read, initial and sign at the bottom)

_____As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement for patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

_____All emergency dental services, or any dental services performed without financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

_____Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms to assist in making collections for insurance companies and will credit any collections to the patients account. **However this dental office cannot render services on the assumption that our charges will be paid by an insurance company**.

_____I understand that, **Co-pay and deductible are ESTIMATES ONLY, based on available information from insurance companies in-network or out of network. I understand that any unpaid balance from insurance is patient's or responsible individual's obligation. Any unpaid balances are subject to collection proceedings, if not paid in full. In the circumstance where patients pay more than the network fee(for in-network covered services only) or office fee(Dentist customary fee for non-covered services and out of network fees) based on insurance estimates, refunds will be issued within 60 days of settlement of all claims submitted on behalf of patients.**

_____A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

_____I understand that any fee estimate for this dental care can only be valid for a period of six months from the date of the patient's examination.

_____In consideration for the professional services rendered to me by this practice, I agree to pay the charges for services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges or services shall be as billed unless objected to, by me, in writing, within the time of payment is due. I further agree that a waiver of any breach of anytime or condition hereunder shall not constitute a waiver of any further term or condition, and I further agree to pay all cost and reasonable attorney's fees if suit be instituted hereunder.

_____I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

_____I have read the above conditions of treatment and payments and agree to their content.

Relationship to Patient: _____

Signature: _____

Name :_____ Date: _____

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AUTHORIZATION TO RELEASE DENTAL RECORDS

I hereby grant Sunrise dental or my treating dentist permission to release **ANY or ALL** of my dental records to the persons identified below. I also understand that only digital copies of documents may be forwarded/transferred via email. I also authorize the below stated individuals to discuss **ANY TREATMENT PLANS and MAKE PAYMENT** arrangements on my behalf.

I understand that the above authorization is voluntarily given and may withdraw the authorization at any time for any individuals. I also understand that any such request must be in writing only. Verbal authorizations or any other form of authorization is not valid unless approved by Sunrise dental.

Name: _____ Email: _____
Phone:_____ Relation:_____

Name: _____ Email: _____
Phone:_____ Relation:_____

Name: _____ Email: _____
Phone:_____ Relation:_____

_____ _____
Patient Signature (Parent if pt. is a minor) Date

_____
Patient Name (Please PRINT)