Leslie Farias DDS
Family Dental Care PLLC

# Dental History

Date: _____

## Patient Information

Full Name: _____ DOB: _____

What is the reason for your visit today? _____

Date of last dental visit: _____ Date of last full mouth x-rays: _____

Previous Dentist's Name: _____ Phone #: _____

Address: _____ City, State: _____ Zip: _____

Do you have any dental problems now? Yes No If yes, please describe _____

_____

## Please indicate if you have had any of the following

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Blisters on lips
- ☐ Clenching or grinding
- ☐ Clicking or popping of the jaw
- ☐ Dental implants
- ☐ Dry mouth
- ☐ Fingernail biting
- ☐ Food collection between teeth
- ☐ Growths in your mouth
- ☐ Gums swollen or tender
- ☐ Jaw pain
- ☐ Loose teeth
- ☐ Mouth breathing
- ☐ Mouth guard
- ☐ Mouth sores
- ☐ Orthodontic treatment
- ☐ Pain around ear
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Teeth whitening

How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use? (electric toothbrush, waterpik, etc.) _____

Do you smoke? Yes No Do you chew tobacco? Yes No

How would you rate your smile? Worst 1 2 3 4 5 6 7 8 9 10 Best

## I would like to learn more about…

- ☐ Orthodontics
- ☐ Whitening
- ☐ Implants
- ☐ Bridges
- ☐ Veneers

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# Financial Policy

**Welcome and thank you for choosing Dr. Farias for your dental care.**
We are committed to providing you with quality dental care. Our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other area dentist's charges. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

**Regarding insurance**

**Indemnity and Private Insurance Policies:** As a courtesy to you, we will file claims directly with your insurance carrier for services rendered. Unfortunately, insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, co-pays, deductible or fees for non-covered services when applicable, is required at the time of service. The amount your insurance company calls "usual and customary" refers to your insurance contract, not our fees.

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the insurance carrier has not paid within this time, you are responsible for the entire balance without further notice. We will not become involved with disputes between you and your insurance company regarding deductible, non-covered services, co-insurance, co-payments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

**Method of Payment:** For your convenience, we will be happy to accept your personal check, cash, Visa, MasterCard, Discover, or American Express for payment of your dental services. A $30.00 fee will be accessed to your account for all returned checks.

**Minors:** The parent(s) or guardian(s) of a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have authorization for dental treatment signed by a parent or guardian and is responsible for current insurance information for self and/or payment in full for services provided.

*I have read, understand, and accept the above terms and conditions and will verify so by giving my signature.*

Signature: _____ Date: _____

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# New Patient

Date: _____

## Patient Information

Full Name: _____ Gender: M/F DOB: _____ Age: _____

Marital Status: _____ Spouse's Name: _____

Address: _____ City, State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Occupation: _____

Social Security #: _____ Driver's License #: _____ E-Mail: _____

Who can we thank for referring you? _____

## Responsible Party

Full Name: _____ Relationship: _____

Social Security #: _____ DOB: _____ Driver's License #: _____

Employer: _____ Employer Phone #: _____

Insurance Company: _____ Phone #: _____

Group/Policy #: _____ Patient ID #: _____

Secondary Insurance: _____ Group/Policy #: _____ Phone #: _____

Name of Insured: _____ Relationship: _____

Social Security #: _____ DOB: _____ Driver's License #: _____

Employer: _____ Employer Phone #: _____

## Direct Billing

I hereby authorize payment directly to Leslie Farias Family Dental Care PLLC of the insurance benefits otherwise payable to me. Ultimately, I understand that I am responsible for all charges. I authorize dental care and release of any information relating to dental claims.

Signature: _____ Date: _____

# Notice Of Privacy Practices Acknowledgement

**Leslie Farias DDS Family Dental Care PLLC**
**9405 Huffmeister Road**
**Suite 160**
**Houston, TX 77095**

I understand that, under the Health Insurance Portability & Accountability 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:

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

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 cary 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.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

**Office Use Only**

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement*, but was unable to do so as documented below:

Date _____ Initials _____ Reason _____