KRYSTAL TEAGUE DENTAL

Patient Full Name: _____ Preferred Name:_____
Parent or Guardian Name(s) (if patient is a minor – 18 & under):_____
Date of Birth: _____ Social Security Number: _____-_____-_____
Mailing Address (Address,City,State,Zip):_ _____
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Email Address: _____ Best Phone # to Reach You: □Home □Cell □Work
How may we remind you of upcoming appointment? □ Email □ Text □ Phone
Martial Status (Married/Divorced/Widow/Single) Employer: _____
Who may we thank for referring you to our office? _____

Primary Dental Insurance Information (Leave blank if there is no Dental Insurance to file)
Insurance Company Name: _____
Name of Subscriber (Person who carries the insurance): _____
Subscriber's Social Security Number: _____-_____-_____Subscriber's DOB:_____
Subscriber's ID Number:_____ Group Number: _____
Subscriber's Employer: _____

Secondary Dental Insurance Information (Leave blank if there is no Dental Insurance to file)
Insurance Company Name: _____
Name of Subscriber (Person who carries the Insurance): _____
Subscriber's Social Security Number: _____-_____-_____ Subscriber's DOB: _____
Subscriber's ID Number: _____ Group Number: _____
Subscriber's Employer: _____

Broken Appointment and Cancellation Policy

We hold appointment times especially for you in good faith that you will be here. When patients do not show up or cancel at the last minute (regardless of the reason) we cannot fill the open slot. This results in nonproductive time which results in increased fees for everyone.

There will be a $25 or $50 charge for ALL missed appointments and cancellations with less than **24 business hours** prior to the scheduled appointment time.

We appreciate your understanding as we continue our efforts to provide you with quality dental care at a fair price.

Policy for Filing Insurance

Our office is NOT in any network, however as a courtesy we will file to all dental insurance companies. You will be responsible for any charges your insurance does not pay. If for any reason your insurance company has not paid within 60 days of treatment the balance will be your responsibility and you will need to refile with your insurance company. The patient's estimated portion will be due at the time of service.

By Signing Below, I attest that the above information is correct to the best of my knowledge. I also understand that payment is due when services are rendered and that I will be responsible for any amount that insurance does not cover.

Responsible Party Signature: _____ **Date:** _____

Health History

Are you currently being treated by a physician regularly for a serious health problem? Yes☐ No☐
If yes, please explain and give physician's contact information:_____
_____
_____

Please list all medications you are currently taking (prescribed or over the counter):
_____
_____
_____

Do you have any known allergies to latex, medications, or milk protein (please list):
_____

Have you ever been treated for: (circle all that apply)

Blood pressure	Heart Disease	Stroke	Artificial Joint
Rheumatic Fever	Heart Murmur	Heart Valve	Pacemaker
Hepatitis	Diabetes	Depression	Tuberculosis
Immune Disease	Asthma	Bleeding/Clotting	Dry Mouth

Has a physician told you to take antibiotics before a dental cleaning? _____ If yes, why?
_____

Do you use tobacco? _____ If yes, how much per day? _____

Acknowledgement of Receipt of Notice of Privacy Practices

Krystal Teague Dental is committed to protecting your privacy. We will not release any information about you or your treatment without your consent. Only the people you list below will be authorized to receive your information:

Contact Person: _____ Relationship to You: _____
Contact Person: _____ Relationship to You: _____
Contact Person: _____ Relationship to You: _____

I have been given a copy of Krystal Teague Dental's Notice of Privacy Practices to read. I have been offered a paper copy to take home.

Patient or Responsible Party: _____ **Date:** _____