Welcome to our Practice

PATIENT INFORMATION:

Today's Date _____

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr. First Name _____ M.I. _____ Last Name _____

Sex: ❑ Male ❑ Female Birth Date _____ Age _____ Soc. Sec. # _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Home Tel.(_____) _____ Cell.(_____) _____ Have you ever been a patient of our practice? ❑ Yes ❑ No

Referred By _____ (FIRST NAME) _____ (LAST NAME) Has a family member ever been a patient of our practice? ❑ Yes ❑ No

Dentist _____ (FIRST NAME) _____ (LAST NAME) Orthodontist _____ (FIRST NAME) _____ (LAST NAME) Medical Dr. _____ (FIRST NAME) _____ (LAST NAME)

Driver's Lic.# _____ Nearest relative not living with you _____ (FIRST NAME) _____ (LAST NAME) Tel.(_____) _____

Employer _____ Bus. Tel.(_____) _____ Personal Payment Type: ❑ Cash ❑ Check ❑ Credit Card

In case of emergency, please contact _____ Tel. (_____) _____ Relation _____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT:

❑ Self (If self, skip this section) ❑ Spouse ❑ Father ❑ Mother ❑ Other _____

Name _____ (FIRST NAME) _____ (LAST NAME) S.S.# _____ Birth Date _____ Age _____

Tel.(_____) _____ Cell. (_____) _____ E-mail _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Driver's Lic.# _____ Employer _____ Bus. Tel.(_____) _____

SPOUSE OR OTHER GUARANTOR INFORMATION: *(IF DIFFERENT FROM ABOVE)*

Name _____ (FIRST NAME) _____ (LAST NAME) Relation _____ S.S.# _____ Birth Date _____

Street _____ Apt. _____ City _____ State _____ Zip _____

Tel. (_____) _____ Employer _____ Bus. Tel.(_____) _____

INSURANCE INFORMATION:

Student: . . . . . ❑ Full Time ❑ Part Time ❑ Not . . . . . School Name and Address _____ (SCHOOL NAME) _____ (ADDRESS)

Marital Status: . ❑ Married ❑ Divorced ❑ Widow ❑ Single ❑ Legally Separated _____ (CITY) _____ (STATE) _____ (ZIP)

Employed: . . . . ❑ Full Time ❑ Part Time ❑ Retired ❑ Not. . . . . Do you belong to a PPO or HMO? ❑ Yes ❑ No

PRIMARY DENTAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

PRIMARY MEDICAL INSURANCE COMPANY:

Employer _____

Bus. Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Bus. Tel.(_____) _____ Plan _____

Ins. Co. Name _____ I.D. # _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

Tel.(_____) _____ Group Name _____

Group # _____ Insured Party _____ (FIRST NAME) _____ (LAST NAME)

Relation _____ Birth Date _____ Sex: ❑ M ❑ F

S.S. # _____ Tel.(_____) _____

Address _____ (ADDRESS) _____ (CITY) _____ (STATE) _____ (ZIP)

HEALTH HISTORY FORM

Patient's Name _____ **Date of Birth** _____/_____/_____

Gender _____ **Height** _____ **Weight** _____ **Today's Date** _____

An accurate and complete health history will assist in coordinating your dental care.
Please speak with the doctor or staff if there are any questions about this form.

DENTAL HISTORY

Please describe your current dental health: Excellent Good Fair Poor
Please describe why you are in the office today_____

Have there been any changes in your dental health in the past year? Yes / No
If yes, please describe_____

Are you having any dental discomfort at this time? Yes / No
If yes, please describe_____

Have you had any adverse effects from dental treatment? Yes / No
If yes, please describe_____

Date of last dental visit?_____

DENTAL HISTORY - Do you have or have you ever had any of the following:

Bleeding, sore gums?	Yes / No	Shifting in bite?	Yes / No
Unpleasant taste/bad breath?	Yes / No	Change in bite?	Yes / No
Swelling/lumps in mouth?	Yes / No	Burning tongue/lips?	Yes / No
Orthodontic treatment (braces?)	Yes / No	Frequent blister, lips/mouth?	Yes / No
Clenching/grinding?	Yes / No	Sensitive teeth (hot or cold?)	Yes / No
Sensitive to sweets?	Yes / No	Clicking/popping jaw?	Yes / No
Sensitive to biting?	Yes / No	Difficulty opening or closing jaw?	Yes / No
Food Impaction?	Yes / No	Loose teeth?	Yes / No
Biting cheeks/lips?	Yes / No		

MEDICAL HISTORY

Please describe your current overall health: Excellent Good Fair Poor
Have there been any changes in your general health in the past year? Yes / No
If yes, please describe: _____

Are you now under a doctor's care for a medical condition? Yes / No Date of last physical exam?_____
If yes, please describe_____
Name of physician_____ Physician phone number_____

Have you ever been hospitalized or had a serious illness? Yes / No
If yes, please describe_____

Have you ever had surgery? Yes / No
If yes, please describe_____
_____
_____

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

MEDICAL HISTORY (continued) - Do you have, or have you ever had, any of the following conditions:

Congenital heart disease, cardiovascular disease – like heart attack, heart murmur, coronary artery disease, chest pain, high/ low blood pressure, stroke, irregular heartbeat, heart surgery, pacemaker?	Yes / No	Lung disease – like asthma, emphysema, COPD, chronic cough, bronchitis, pneumonia, tuberculosis, shortness of breath, chest pain, severe coughing?	Yes / No
Implants placed anywhere in the body – like heart valve, pacemaker, hip, knee?	Yes / No	Bleeding disorder, anemia, bleeding tendency, blood transfusion, or bruise easily?	Yes / No
Kidney disease or kidney failure, requiring dialysis?	Yes / No	Liver disease – like jaundice, hepatitis A, B, or C?	Yes / No
Thyroid disease?	Yes / No	Arthritis?	Yes / No
Stomach ulcers or colitis?	Yes / No	Significant weight loss or gain?	Yes / No
Diabetes?	Yes / No	Sinus or nasal problems?	Yes / No
Glaucoma?	Yes / No	Sleep apnea?	Yes / No
Cancer?	Yes / No	Osteoporosis or osteopenia?	Yes / No

If yes, type_____

Diagnosis date_____

Treatments_____

Do you have any other medical conditions that are important for your doctor to know about? Yes / No
If yes, please describe_____
_____

FAMILY MEDICAL HISTORY - Do you have a family history of any of the following conditions?

Diabetes?	Yes / No	Relationship_____	Heart disease?	Yes / No	Relationship_____
Lung disease?	Yes / No	Relationship_____	Bleeding problems?	Yes / No	Relationship_____
Cancer?	Yes / No	Relationship_____			

Has an immediate family member had any problems with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No
If yes, please describe_____

MEDICATIONS – Are you currently prescribed or taking any of the following:

Antibiotics?	Yes / No	Prescription pain medication?	Yes / No
Anticoagulants or blood thinners?	Yes / No	Aspirin or drugs such as Motrin, Aleve, Ibuprofen?	Yes / No
Heart medications?	Yes / No	Insulin or oral anti-diabetic drugs?	Yes / No
Steroids – like cortisone or prednisone?	Yes / No	Blood pressure medications?	Yes / No
Antianxiety agents, antidepressants, or other psychiatric medications?	Yes / No	Bisphosphonates or other medications to strengthen your bones?	Yes / No
Cancer or chemotherapy drugs?	Yes / No	Any other medications or supplements?	Yes / No

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

MEDICATIONS (continued): Please list the specific medications indicated above and/or any other medications not listed above that you are currently taking. Please including all prescription medications, diet drugs, over the counter medications, herbal or holistic remedies, vitamins, or minerals:

Medication and dose	**Medication and dose**

ALLERGIES – Are you allergic to or have you had an adverse reaction to:

Latex?	Yes / No	Codeine or other pain control medications?	Yes / No
Food or food products?	Yes / No	Aspirin, ibuprofen (Motrin), or naproxen (Aleve)?	Yes / No
Sedatives or barbiturates?	Yes / No	Penicillin or other antibiotics?	Yes / No
Any other medications?	Yes / No	Any other allergies?	Yes / No

If yes, please describe_____

_____

ANESTHESIA HISTORY

Have you had any problem associated with local anesthesia, general anesthesia, and/or intravenous sedation? Yes / No
If yes, please describe_____

FEMALE PATIENTS Are you pregnant? Yes / No Is there any chance you might be pregnant? Yes / No

SOCIAL HISTORY

Have you ever smoked, vaped or chewed tobacco? Yes / No
If yes, for how long?_____

Have you ever sought professional care or been hospitalized for:
- Substance abuse Yes / No
- Emotional disorders Yes / No
- Alcoholism Yes / No

Do you use:
- Alcohol? Yes / No If yes, how often per week?_____
- Marijuana? Yes / No If yes, how often per week?_____
- Recreational drugs? Yes / No If yes, how often per week?_____

DO YOU WISH TO TALK TO THE DOCTOR ABOUT ANYTHING IN PRIVATE? Yes / No

I understand the importance of a truthful and complete health history to assist my doctor in providing coordinated care. To the best of my knowledge, the above information is complete and correct.

_____ _____
Signature of patient, parent, guardian Date

_____
Printed name of patient, parent, guardian/Relationship

HEALTH HISTORY FORM

Patient's Name _____ Today's Date _____

For office staff use - HEALTH HISTORY REVIEW

Date	Comments	Doctor's Signature
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

For office staff use - ADDITIONAL CLINICAL DOCUMENTATION

Implants & Oral Surgery, PC

Office of Drs. Diana Lois & Eduardo Humes

Office Financial Policy

BASIC POLICY: **Payment for services rendered is due in full at the time of service**. A 10% down payment is required at least 72 hours prior to any scheduled procedure in order to secure your appointment time. There is a $30 returned check fee due and payable from you for each check payment returned to us by your bank. A collection charge of 35% of the remaining balance, not to exceed $40, will be added to any additional delinquent accounts.

FOR PATIENTS WITH IN NETWORK INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided in advance. We do not bill secondary insurance but will provide information to aid you in the process. Every effort will be made to closely **estimate** your co-payments and deductibles, which are due at the time of the service, **but the ultimate responsibility for the unpaid balance rests on you**.

FOR PATIENTS WITH OUT OF NETWORK INSURANCE: As a service to our patients, we will accept "assignment of benefits" and will bill your insurance carrier, provided proper paperwork is provided in advance. We do not bill secondary insurance but will provide information to aid you in the process. Every effort will be made to closely **estimate** your co-payments and deductibles, which are due at the time of the service, **but the ultimate responsibility for the unpaid balance rests on you**. Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality care at a reasonable cost to our patients. In fairness to other patients, and the doctor, we require at least 72 hours notice when cancelling a consultation appointment. **There is a $50 fee for missed appointments without a 72 hour notification.** We will require information for a valid credit/debit card in order to book a consultation appointment. Failure to cancel a consultation appointment with at least 72 hours notice will result in a $50 fee.

I understand that my signature requests payment to be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA – 1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown.

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion or such charges.

Patient's Name (please print) _____

Responsible Party's signature _____

I agree to be responsible for all charges for rendered oral surgical services and materials not paid for by my dental or medical insurance carrier, unless the provider or practice has a contractual agreement with my plan prohibiting all or portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

Patient and/or responsible party's signature _____ **Today's date** _____

I hereby authorize payment of dental or medical benefits otherwise payable to me directly to the practice Implants & Oral Surgery, PC, Dr. Diana Lois, Dr. Eduardo Humes.

Patient and /or responsible party's signature _____ **Today's date** _____

IMPLANTS AND ORAL SURGERY, PC.
Patient Disclosure Instructions

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

- ❑ Home / Cell Telephone Number_____
  - ❑ O.K. to leave a message with detailed information
  - ❑ Leave message with call back number only
- ❑ Work Telephone Number _____
  - ❑ O.K. to leave a message with detailed information
  - ❑ Leave message with call back number only
- ❑ Written Communication
  - ❑ O.K. to mail to my home address
  - ❑ O.K. to mail to my work / office address
  - ❑ O.K. to mail to my e-mail address_____

I allow you to give my clinical information to, or answer questions from (check all that apply):

- ❑ Spouse
- ❑ Parent
- ❑ Child
- ❑ Other (specify) and relationship_____
- ❑ None

Patient Signature Date

Print Name Birth 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 ❑ Communication barriers prohibited obtaining the acknowledgement ❑ An emergency situation prevented us from obtaining acknowledgement ❑ Other (specify) _____

COVID-19 ACKNOWLEDGEMENT OF RISK AND HEALTH SCREENING FORM

_____ _____

Patient's Name Date of Birth

Our practice wants to ensure you are aware of the relative risks of exposure to COVID-19 associated with receiving treatment. This practice has always followed the applicable state and federal regulations and recommendations regarding infection control, sterilization, disinfection, and the use of PPE (personal protective equipment). We also work to protect our patients and office staff from virus spread by promoting frequent hand washing and office cleaning, using PPE for patient encounters, and adding additional environmental controls in the treatment areas.

Although we are using enhanced infection control measures in our practice, due to the nature of the procedures we provide, it is not possible to maintain social distancing during treatment or for you to wear a mask during treatment. This means that the risk of exposure to COVID-19 remains when receiving treatment during the pandemic.

COVID Health History

Have you ever been diagnosed with COVID-19?	YES	NO	If yes, when? _____
Have you ever been hospitalized for COVID-19 treatment?	YES	NO	If yes, when? _____
Are you fully vaccinated or in the course of being vaccinated for COVID-19?	YES	NO	
Have you been tested for COVID-19 and are awaiting results?	YES	NO	
In the last 14 days, have you been in contact with any confirmed cases of COVID-19?	YES	NO	

Symptoms – Today, or in the last 14 days:

Have you had a fever or felt hot or feverish?	YES	NO
Have you had any shortness of breath or other breathing difficulties?	YES	NO
Have you had a cough?	YES	NO
Have you had any other flu-like symptoms, such as an upset stomach, headache, or fatigue?	YES	NO
Have you had a loss of taste of smell?	YES	NO
Have you otherwise felt unwell?	YES	NO

Patient Acknowledgement - By signing this document, I acknowledge that I have read the Patient Acknowledgment and that I understand and accept that there is a risk of COVID-19 exposure with treatment. I also acknowledge that the Health History and Health Screening answers I have provided are true and accurate.

_____ _____

Patient or Legal Representative Signature Date

_____

Print Patient or Legal Representative Name/Relationship

_____ _____

Witness Signature Date

IMPLANTS AND ORAL SURGERY, PC.
Diana Reyes Lois, D.D.S.
Eduardo A. C. Humes, D.D.S., M.P.H.
www.ftwosa.com

7217 Hawkins View Dr., Suite 200
Fort Worth, Texas 76132
817-292-3605 Fax 817-292-1743

707 Paluxy Road
Granbury, Texas 76048
817- 573-1855 Fax 817-573-4985

CREDIT CARD ON FILE AGREEMENT

Implants and Oral Surgery PC has implemented a new credit card policy. Like many other practices and medical offices, we have adopted a similar policy. We kindly request our patients and or patients' guardian/guarantor for a credit card which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance has paid their portion and notifies us of the balance due, if any.

The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card five (5) days from the date of notice. You may call our office if you have a question about your balance. We will send you a receipt for the charge. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have any questions about the card-on-file payment method, please do not hesitate to let us know.

By signing below, I authorize Implants and Oral Surgery PC to keep my signature and my credit card information securely on-file in my account. I authorize Implants and Oral Surgery PC to charge my credit card for any outstanding balances when due.

VISA __ MASTERCARD__ DISCOVER__ AMERICAN EXPRESS___

Name on Card (Print):_____

Cardholder Relationship to Patient:_____

Last Four Digits of Credit Card Number:_____Exp. Date:___/___

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print):_____DOB:___/___/___

Patient Full Name (Print):_____DOB:___/___/___

Credit Card Holder's Signature:_____ Date:_____

☐ **Please check here if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.**