EST. 2009
EPSTEIN
GENERAL & COSMETIC DENTISTRY

Patient Information Sheet

Patient Name: _____ Middle: _____Last:_____
Preferred Name: _____ Birthdate: _____ SS#:_____
Whom may we thank for referring you? :_____

Address: _____City:_____State:_____Zip:_____
Home Phone: _____Work Phone: _____Cell Phone: _____
Email Address: _____

If patient is a minor, give parent's or guardian's name:

Guardian's Name: _____Relation:_____

Responsible Party Information if Different from Above:
Full Name: _____

Mailing address if different:
Address: _____ City: _____ State: _____Zip: _____
Home Phone: _____Work Phone: _____Cell Phone: _____
Email Address: _____

Dental Insurance Information

Subscriber Information:

Name: _____ Middle: _____ Last: _____
Member ID #: _____ Birthdate: _____
Employer: _____ Social Security Number: _____
Insurance Company: _____Group Number: _____

Insurance Company Address: _____ City: _____
State: _____ Zip Code: _____ Phone Number: _____

Do you have Secondary Dental Insurance? YES / NO (If yes please complete secondary information)

Secondary Subscriber's Information:

Name: _____ Middle: _____ Last: _____
Member ID #: _____ Birthdate: _____
Employer: _____ Social Security Number: _____
Insurance Company: _____ Group Number: _____

Secondary Insurance Information (if applicable)

Insurance Company Address: _____City:_____
State: _____Zip Code: _____Phone Number: _____

Medical History

Physician: _____Date of last visit: _____
Address Street: _____City: _____State:_____Zip:_____
Phone Number: _____ Last Complete Physical? _____

How is your general health? : EXCELLENT GOOD FAIR POOR

Are you taking any medications now? (If so please list below)
_____
_____
_____

Please check any of the following that you have had or currently have:

◯ **HEART DISEASE/SURGERY** ◯ PACEMAKER ◯ **ABNORMAL BLOOD PRESSURE** ◯ **CONGESTIVE HEART FAILURE**
◯ CONGENITAL HEART LESIONS ◯ HEART MURMER ◯ ARTIFICIAL HEART VALVE ◯ **AFIB** ◯ **STROKE**
◯ ULCERS ◯ EATING DISORDERS ◯ **ACID REFLUX** ◯ GI ISSUES ◯ ANEMIA ◯ HEPATITIS Type_____◯ JAUNDICE
◯ BLOOD DISEASE ◯ HYPOGLYCEMIA ◯ KIDNEY DISEASE ◯ THYROID DISEASE ◯ LIVER DISEASE ◯ ARTHRITIS
◯ GLAUCOMA ◯ TUBERCULOSIS ◯ EPILEPSY/SEIZURES ◯ **DIABETES Type_____** ◯ CANCER TYPE_____
◯ CHEMOTHERAPHY ◯ SEXUALLY TRANSMITTED DISEASE Type_____ ◯ COLD SORES/FEVER BLISTERS ◯ AIDS/HIV
◯ SINUS TROUBLE ◯ ASTHMA OR HAY FEVER ◯ COPD/EMPHYSEMA/LUNG DISEASE ◯ FREQUENT COUGH
◯ SHORTNESS OF BREATH◯ SERIOUS ACCIDENT ◯ RHEUMATIC FEVER ◯ RHEUMATISM ◯ NEUROLOGICAL CONDITION
◯ CHEMICAL DEPENDENCY ◯ PSYCHIATRIC CARE ◯ ANXIETY/NERVOUSNESS ◯ **DEPRESSION** ◯ **ADHD**
◯ **SNORING** ◯ **SLEEP APNEA** ◯ **EXCESSIVE DAYTIME SLEEPINESS** ◯ **HEADACHES** ◯ **OTHER_____**

Have you ever had **head** or **neck** radiation treatment? YES / NO

Have you ever taken Fosamax, Boniva, Aredin, Actonel, Skelid, Zometa? YES / NO

Have you ever had joint replacement surgery? YES / NO
Are you subject to prolonged bleeding? YES / NO

Do you require premedication? YES / NO
Are you subject to fainting spells? YES / NO

Women:

Are you pregnant? YES NO If yes, due date? _____

Are you allergic to any medications? (Penicillin, Codeine, Local anesthetics): YES / NO (if yes please list)

_____

_____

Dental History

Previous Dentist: _____Date of last dental visit: _____
Phone number: _____

Are you happy with the appearance of your teeth? YES / NO
Have you had orthodontic treatment? YES / NO
Do you clench or grind your teeth during the day or night? YES / NO
Have you ever had pain in your jaw joint or face? YES / NO
Do you have an unpleasant odor, or taste, in your mouth? YES / NO
Have you had gum disease or pyorrhea? YES / NO
Is your mouth sensitive? YES / NO, if yes are you sensitive to: ◯ pressure ◯ hot ◯ cold

Is there a specific need/desire you'd like to discuss with Dr. Epstein? YES / NO if so please list_____

_____

_____

Indicate any disease, condition, or problem not listed above that you think we should know about:

_____

_____

Emergency information

Emergency person: _____Relation:_____
Phone number: _____Alt phone number_____

Cancellation Policy Acknowledgment

NO SHOW POLICY: In order to be respectful of other patient's needs, please be courteous and call our office within a 24-hr period if you are unable to make an appointment. Any appointment(s) not cancelled 24-hrs in advance may be subject to a $75.00 cancellation fee. By signing below, you agree to the above mentioned terms.

Patient signature: _____Date_____
If under 18, Parent or Guardian signature: _____

THE WOODLANDS DENTAL GROUP
DR.DAVID B. EPSTEIN DDS
FINANCIAL AGREEMENT

Welcome, and thank you for choosing Dr. Epstein for your dental care. We are dedicated to providing the highest quality dentistry in an efficient, caring and comfortable environment. We have prepared the following summary so we may help you avoid any frustration or misunderstanding regarding our office policies.
Discounts: We offer a 5% cash discount for any treatment over $1,000 if your portion is paid in full the day the treatment is started. We also offer a 5% senior discount for anyone over 65, or a 10% discount if you are over 65 and have been with our practice for 15 years or more. We also offer interest free financing with Care Credit. 6 & 12 month plans available.

Insurance: Filing an insurance claim is a courtesy we gladly extend to our patients. WE MUST EMPHASIZE that our relationship is with YOU, our patient, NOT the insurance company. Being an OUT OF NETWORK office allows us to provide the best services, treatment and material possible. We gladly accept any PPO insurance plans.
Our patients, who have dental insurance, will be asked to pay their estimated portion at the time of treatment. We do ask that the correct insurance information be provided at the time of your appointment in order for us to timely file the claim and collect payments. If this information changes, it is the patient's responsibly to update our office 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 Dr. Epstein. We do accept payments from dental insurance companies; however, we are not contracted with them and we are not responsible for knowing what your insurance plan covers and does not cover. It is a contract between you, your employer and the insurance company.

Account Balances/Charges: Any difference in payment from your insurance company and your account balance is your responsibility. Even though your insurance company says it pays a certain percentage, understand that it is a percentage of their customary fees, NOT the fees we charge. If your insurance has not paid within 90 days, your account will be charged to your credit card on file. Or last credit card used. If this is not paid in full within 120 days, or on a payment plan, the account is at risk of being sent to collection agency. (Please note; any returned check will be subjected to a $30 returned check fee.)

I understand that all responsibility for payment of dental services in the office for myself or my dependents is mine. Payment is due and payable at the time that services are rendered.

Signature: _____ Date: _____

Acknowledgment of receipt of Notice of Privacy Practice and HIPPA Communication Consent Form

Patient name: _____Date of Birth: _____

This consent form allows Dr. David Epstein, The Woodlands Dental Group to use and disclose information about me protected under the Health Insurance Portability and Accountability Act of 1996. This information may be used or disclosed to carry our treatment, payment or health care operations.

Dr. David Epstein, The Woodlands Dental Group has provided me with a Notice of Privacy Practices, which more completely describes such uses and disclosures. It provided this notice prior to my signing this form in accordance with my right to review its practices before signing consent.

_____ (initial) I understand that the terms of the Notice of Privacy Practice may change and that I may obtain revised notices by contacting the Privacy Officer at Dr. David Epstein, The Woodlands Dental Group.

_____ (initial) I hereby authorize that Dr. David Epstein, The Woodlands Dental Group may leave messages on my voicemail to confirm appointments, and/ or may speak with other members of my household and leave message with them regarding my appointments.

_____ Email _____ Home Phone _____ Office Phone _____ Cell Phone

_____ (initial) I hereby authorize that Dr. David Epstein, The Woodlands Dental Group may disclose my health information to any person(s) who accompany me to my appointment, and are present with me in the office while I meet with my dentist and staff.

_____ (initial) I hereby authorize that Dr. David Epstein, The Woodlands Dental Group may disclose my personal health information to the person who I have listed as my emergency contact.

_____ (initial) I hereby authorize that Dr. David Epstein, The Woodlands Dental Group may disclose my personal health information to the following person(s):

Name_____ Contact Number _____ Relationship to Patient_____
Name_____ Contact Number _____ Relationship to Patient_____
Name_____ Contact Number _____ Relationship to Patient_____

_____ (initial) I understand that at any time I have the right to revoke this consent provided that I do so in writing, but that Dr. Epstein, The Woodlands Dental Group services may still use information to complete any actions that it began prior to my revoking consent and which rely on my protected health information. I understand that Dr. David Epstein may refuse services if I revoke this consent.

_____ (initial) I understand that I have the right to request now and in the future how protected health information is used or disclosed to carry out treatment, payment and health care operations, and must be provided by me in writing. I understand that while Dr. David Epstein is not required to agree to my requested restriction, if it does agree, it is bound by that agreement. *By my signature below, I affirm the above information.*

Signature of Patient: _____Date:_____
Signature of Parent (if minor): _____ Date: _____
Authorized Representative_____ Date: _____