David B. Epstein DDS
281-367-3085
1001 MEDICAL PLAZA DR # 300, THE WOODLANDS, TX77380
drepstein@thewoodlandsdental.com

Patient Information

First Name: _____

Middle Name: _____

Last Name: _____

Preferred Name: _____

Address

Street: _____

City: _____

State: _____

Zip Code: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Email Address: _____

Birthdate: _____

Employer: _____

Occupation: _____

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

_____

Referred by: _____

Responsible Party Information

Full Name: _____

Mailing address if different:

Street: _____
City: _____

State: _____

Zip Code: _____

Cell Phone: _____

Email Address: _____

If patient is under 18, please complete this section:

Social Security Number: _____

Birth Date: _____

Relationship to the Patient: _____

Employer: _____

Dental Insurance Information

Insured's Name: _____

Employer: _____

Insured's Social Security Number: _____

Insurance Company: _____

Group Number: _____

Member ID #: _____

Insurance Company Address:

Street: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Do you have Secondary Dental Insurance? **YES** **NO**

Insured's Name: _____

Employer: _____

Insured's Social Security Number: _____

Insurance Company: _____

Member ID #: _____

Secondary Insurance Company Address:

Street: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

Medical History

Physician: _____

Date of last visit: _____

Address:

Street: _____

City: _____

State: _____

Zip Code: _____

Phone Number: _____

How is your general health: EXCELLENT GOOD FAIR POOR

Last Complete Physical? _____

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	ABNORMAL BLOOD PRESSURE
RHEUMATIC FEVER	ULCERS, EATING DISORDERS, ACID REFLUX
TUBERCULOSIS	EPILEPSY
DIABETES TYPE 1	DIABETES TYPE 2
ANEMIA	CONGENITAL HEART LESIONS
HERPES	SEXUALLY TRANSMITTED DISEASE (STD)
CANCER	HEADACHES
HEART MURMER	JAUNDICE

SINUS TROUBLE	ASTHMA OR HAY FEVER
COUGH	HEPATITIS
ARTHRITIS	STROKE
GLAUCOMA	SERIOUS ACCIDENT
AIDS/HIV	KIDNEY DISEASE
SNORING	SLEEP APNEA

Other:_____

Have you ever had radiation treatment?	YES	NO
Do you have a pacemaker?	YES	NO
Have you ever taken Fosamax, Boniva, Aredin, Actonel, Skelid, Zometa?	YES	NO
Have you ever had joint replacement surgery?	YES	NO
Excessive sleepiness during the day?	YES	NO
Are you subject to prolonged bleeding?	YES	NO
Are you subject to fainting spells?	YES	NO

Women:

Are you pregnant?	YES	NO

If so, how far along? _____

Are you allergic to any medications? (Penicillin, Codeine, Local injected anesthetics):

_____

_____

Dental History

General Dentist: _____

Date of last 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
Do your gums bleed when brushing?	YES	NO
Have you had gum disease or pyorrhea?	YES	NO
Is your mouth sensitive to pressure?	YES	NO
Is your mouth sensitive to hot temperatures?	YES	NO
Is your mouth sensitive to cold temperatures?	YES	NO
Does food catch in between your teeth?	YES	NO

Please add anything you feel is important for the doctor to know: _____

_____

_____

_____

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

_____

_____

Emergency information

Emergency person: _____

Phone number: _____

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 certify that the above information is correct and accurate to the best of your knowledge.

Patient signature: _____

Parent or Guardian signature: _____

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THE WOODLANDS DENTAL GROUP

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 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:_____

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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 are 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.

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.

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
Initial regarding my appointments.

___ Email ___ Home Phone ___ Office Phone ___ Cell Phone

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
Initial dentist and staff.

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	**Telephone Number**	**Relationship to Patient**

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.

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)
/ Authorized Representative_____Date:_____