The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain optimal oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Dr. Heather Magers & Dr. John Barroso

101 NW Renfro, Suite 104
Burleson, Texas 76028
**817.447.6040**
**www.legacydentaltexas.com**


## 1 ABOUT YOU

Today's Date:

Email Address:

Name:
Last First Mr Mrs Ms Dr

I prefer to be called: Male Female

Birthdate: Age: SS#:

Home Address: Apt/Condo #:

City State Zip

Single Married Partnered

Divorced/Separated Widowed

Home #: Cell #:

Work #: Ext: DL#:

Employer:

How long there? Occupation:

When/where are best times to reach you?

Whom may we thank for referring you?

Other family members seen by us:

Previous / Present Dentist:

Reason for leaving previous dentist:

Last Visit Date:

### Spouse Information

His / Her Name:

Employer:

Work #: Ext: SS#:

Birthdate: DL #:

### Person Responsible for Account

His / Her Name:

Work #: Cell #:

Billing Address:

Relationship: SS #:

Employer: DL #:

### Current Smile/Oral Health

How would you rate your current dental health (1-10)?

What would you like to change about your smile?

## 2 INSURANCE

Has your insurance changed? Yes No

Dental Coverage? Yes No

Insurance Co. Name:

Insurance Co. Address:

Insurance Co. Phone #:

Group # (Plan, Local, or Policy #):

Insured's Name: _ Relation:

Insured's Birthdate: _ Insured's ID #:

Insured's Employer:

## 3 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name:

Phone #: Date of last visit:

Are you currently under the care of a physician: Yes No

Please explain:

Preferred Pharmacy:

Phone # City:

Your current physical health is: Good Fair Poor

## 3 MEDICAL HISTORY (Cont.)

Do you smoke? Yes No
Do you use smokeless tobacco? Yes No
Do you vape? Yes No
Have you had any metal rods, pins or implants? Yes No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? List below: Yes No

Have you ever taken Fosamax or another bisphosphonate? Yes No

For Women: Are you using a prescribed birth control? Yes No

Are you pregnant? Yes No Week#
Are you nursing? Yes No

Have you ever had any of the following diseases or medical problems:

**Yes No** **Yes No**

Abnormal Bleeding
Alcohol / Drug Abuse
Anemia
Arthritis
Artificial Bones/Joints/Valves
Asthma
Blood Transfusion
Cancer / Chemotherapy
Colitis
Congenital Heart Defect
Diabetes - Type/A1C:
Difficulty Breathing
Emphysema
Epilepsy
Fainting Spells
Glaucoma
Hay Fever
Heart Attack – Year:
Heart Murmur
Heart Surgery
Hemophilia
Hepatitis - Type/Year Diagnosed
Fever Blisters

High Blood Pressure
Hip Replacement – Year:
HIV + / AIDS
Hospitalized for any reason
Human Papillomavirus (HPV)
Kidney Disorder
Knee Replacement – Year:
Liver Disease
Low Blood Pressure
Lupus
Mitral Valve Prolapse
Osteoporosis / Paget's Disease
Pacemaker – Year:
Radiation Treatment
Rheumatic / Scarlet Fever
Seizures
Shingles
Sickle Cell Disease / Traits
Sinus Problems
Stroke
Thyroid Problems
Tuberculosis (TB)
Ulcers
Venereal Disease

Please list any serious medical condition(s) that you have ever had:

Any surgeries in the past 5 years?

Are you allergic to any of the following?

**Yes No** **Yes No** **Yes No**

Aspirin
Codeine
Latex

Erythromycin
Dental Anesthetics
Penicillin

Tetracycline
Other

Please list any other drugs/materials that you are allergic to:

## 4 DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No
Are you currently in pain? Yes No
Are you aware of any clenching and/or grinding? Yes No
Do you get frequent headaches? How often? Yes No
Do your jaws click? Yes No
Do you sleep well? Yes No
Do you feel rested when you wake up? Yes No
Do you have acid reflux Yes No
Have you been told you have a sleep disorder (apnea)? Yes No

## 5 EMERGENCY CONTACT

Emergency Contact Name:

Relationship to Patient: Phone:

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

**Payment is due in full at the time of treatment** unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payments and deductibles that my insurance does not cover.

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient Signature Date

Doctor Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

## 6 INSURANCE AGREEMENT

Thank you for choosing our office to provide you with upscale dentistry with a small town feel. If at any time you have questions regarding our financial policy or insurance agreement, please feel free to ask a business member of our team.

**Dental Insurance**

- Legacy Dental is an out-of-network dental provider for some insurance. An out-of-network provider is not contracted with the dental insurance plan. However, our office will file any insurance for you for up to 60 days. After that, the total unpaid balance becomes your responsibility.
- Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not part of this contract. Our connection is with you, and not the insurance company.
- Often, an insurance company will use a fee schedule or UCR (usual, customary, and reasonable) fee list. This means that they arbitrarily set their own prices for every dental procedure they cover. This is not based on what a dentist office actually charges, or the cost of the procedure in a geographic region, but what dental insurance believes we should be charging for a dental procedure. For example, insurance may claim they will cover your cleaning at 100%. The cleaning may cost $85; although, your insurance company will only allow $65 because that is the UCR fee. Leaving you with a balance of $20.
- Even though we may estimate your insurance benefits based on the information provided by your insurance carrier, it is not our responsibility for the accurateness of the estimate. Knowledge of benefits, the benefit amount, exclusions, waiting periods, missing tooth clauses, frequencies, etc. is your responsibility.
- **Exclusions:** Exclusion is a provision within an insurance policy that eliminates coverage for a certain service.
- **Waiting periods:** A waiting period is the length of time an insurance company will make you wait after you are covered before they will pay for certain procedures.
- **Missing Tooth Clause:** Missing Tooth Clause allows the insurance to not cover the replacement of a tooth that was missing before the policy was in effect.
- **Frequency:** How often an insurance company will pay for a procedure.
- If you are a member of Delta Dental Insurance they do not allow "assignment of benefits". Meaning the insurance check goes to the patient and not the doctor. In this case, we will file your insurance for you; however, you will be responsible for payment in full when services are rendered.
- Services not paid or covered by your insurance company for any reason are your responsibility, despite the reason for non-payment. Some of the services that we provide may not be covered by your insurance. Additionally, co-payments and deductibles are due at the time services are rendered.

Signature:

Date:

Printed Name:

## 7 FINANCIAL AGREEMENT

**Payment Policy**

- We accept cash, check, and debit/credit cards, including Visa, MasterCard, Discover and American Express. Our office also offers Care Credit; which is a health credit card.
- If the insurance company does not pay the portion that was estimated within 60 days, it is your responsibility to pay it in full within 30 days of the denial.
- Once dental insurance pays their portion, a statement will be sent to the mailing address of the guarantor of the account (the person whom is legally responsible) for the remaining balance. Payment is expected to be paid in full within 30 days of the statement date.
- If your account reaches over a 90-day balance, you will be sent to collections. In that instance you will be responsible for the collection fees, legal fees, and any other fees associated with the collection activity.
- There will be a $35 fee for all returned checks.
- If an appointment needs to be rescheduled, please notify our office at least 48 hours in advance of your appointment. After 2 occurrences with less than a 48-hour notice, a $75.00 deposit will be required at the time of scheduling.
- Patients with no insurance must pay for treatment when services are rendered.

Signature:

Date:

Printed Name:

## 8 HIPAA AUTHORIZATION

**The Health Insurance Portability and Accountability Act of 1996**
**(Authorization to release confidential information)**

I, ,
understand a copy of the Notice of Privacy Practice of this office is available upon request and authorize my insurance company to release all benefits and/or claim information to Legacy Dental and/or National Information Services.

This consent is effective until such a day as I cancel this consent in writing.

I understand that information obtained as a result of this consent will be used for only the purpose it is intended and may be used after the cancellation date for claim information. The duplication of this authorization should be considered valid as the original.

Signature:

Date:

Printed Name:

I authorize Legacy Dental to use photos taken before, after, or during my treatment, for use in advertising or on Social Media Pages.

Signature:

Date: ____________________

LEGACY DENTAL

*Small town feel. Big time smiles*

# PROTECTED HEALTH INFORMATION RELEASE

I ______________________________ give my permission to share my protected health information with the following people:

1.________________________________________DOB___________

2.________________________________________DOB___________

3.________________________________________DOB___________

This consent is set to expire ____________________

My protected health information includes my complete dental record including information regarding insurance and billing. This information may be communicated by phone, mail, or email.

Patient signature

Date signed

Printed name