Patient Information

Date:______________________ SSN:________________________

Patient's Name:____ Age:___________

Home Address:____

City:______________________________ State:______________ Zip:___________________

Home Phone:____________________ Work Phone:___________________ DOB:___________

Cell Phone:______________________ Fax:__________________________

Parent's or Guardian's Name (if minor):____

Whom may we thank for referring you to our office:___________________________________

Responsible Party Information

Name:__________________________________ Age:________ SSN:____________________

Relation to Patient:_________________________ Address:_______________________________

City:______________________________ State:______________ Zip:___________________

Martial Status: ( ) Single ( ) Married ( ) Divorced ( ) Separated ( ) Widowed

How long at this address:__________ Home Phone:______________ Work Phone:_____________

Employer:____________________________ Occupation:________________ # Years Emp:_____

Spouse's Name:_______________________________ Spouse's Employer:____________________

Spouse's Occupation:__________________________ Work Phone:________________________

Insurance Information

Check One: ( ) None ( ) Dental ( ) HMO ( ) PPO ( ) Other______________

Insured's Name:________________________________ Insured's SSN:__________________

Insured's Group #:______________________________ Insured's ID #:__________________

Insurance Co:__________________________________ Insured's DOB:__________________

Insured's Employer:____

Employer's Address:____

City:____________________________________ State:_______________ Zip:_____________

FEES FOR SERVICES ARE DUE AT THE TIME SERVICES ARE RENDERED. IF YOU HAVE INSURANCE, WE WILL HELP YOU DETERMINE COVERAGE AND WILL FILE YOUR CLAIM. THIS INFORMATION IS BASED UPON INFORMATION RECEIVED FROM YOUR INSURANCE CO. AND IS NOT A GUARANTEE OF PAYMENT OF YOUR CLAIM. EACH CLAIM IS REVIEWED AND PAID PER YOUR PLAN PROVISIONS. IF INSURANCE IS FILED, THE RESPONSIBLE PARTY IS RESPONSIBLE FOR THE TOTAL FEE WITHIN 60 DAYS OF TREATMENT. APPROPRIATE CREDIT BUREAU REPORTS MAY BE OBTAINED AS NEEDED.

APPOINTMENTS CANCELLED WITH LESS THAT 24 HOURS NOTICE WILL BE SUBJECT TO A CANCELLATION FEE.

SIGNATURE:____ DATE:____________________

Parent or Legal Guardian

Medical Health Questionnaire

Date:____________________

Name:____Age:____________________

Referred by:____

Please state in your own words why you came to see Dr. Pylant:__________________________________

____

____

Are you allergic to any medications? _____Yes_____No

If so, what medications?____

Do you take prescription medications? _____Yes_____No

If so, what medications?____

____

Do you take non-prescription medications? _____Yes_____No

If so, what medications?____

____

Are you pregnant? _____Yes_____No

Have you ever had surgery or operations? _____Yes_____No

If so, what for?____

____

Do you smoke or use any other form of tobacco? If so, how much and how long have you _____Yes_____No
been smoking or using other forms of tobacco?__________________________________

____

Circle any of the following which you have had or have at present:

Hepatitis
Yellow Jaundice
Syphilis/Gonorrhea
HIV/AIDS
High Blood Pressure
Rheumatic Fever
Heart Murmur
Mitral Valve Prolapse
Chest Pain/Angina
Heart Attack
Chemotherapy
Ankles Swell

Heart Pacemaker
Anemia
Asthma
Bronchitis
Emphysema/COPD
Sinus Trouble
Bleeding Problems
Ulcers
Artificial Joints
Bruise Easy
Steroid Medication

Thyroid Disease
Kidney Problems
Diabetes
Glaucoma
Special Diet/Diet Pills
Tuberculosis
Blood Transfusions
Drug use or addiction
Psychiatric Disorders
Anesthesia Problems
Shortness of Breath

Are you presently under the care of a physician for any reason?______If so for what reason?_______________

____

Date of last general physical: ____

Physician's Name:_______________________________________ Phone #:_____________________

Do you have any other disease, condition, or medical problems not listed above that you think Dr. Pylant should know about?____

____

This is to certify that I, undersigned, have disclosed to Dr. Pylant any and all drugs and medications that I am taking. I have also disclosed any abnormalities in my current physical status and/or past medical history. This includes any history of drug or alcohol abuse and any reactions to medications or anesthetics. I also consent to the performing of the dental procedures agreed to be necessary or advisable including the use of local anesthetic as indicated.

____ ______________________________

Patient or Patient's Guardian Date

____

George D Pylant III, DDS

Dental Health Questionnaire

When did you have X-rays last?____________________
When was your last dental visit?____________________
When did you last have your teeth cleaned?____________________
How often do you have your teeth cleaned?____________________
Have you ever had any gum treatment?...______yes______no
If so, what kind and when?____________________
Is there a history of gum disease commonly known as ‘pyorrhea’ in your family?................______yes______no
Do you currently have any pain in your mouth?...______yes______no
If so, where and when did it begin?____________________

____

Do you have a history of frequent abscesses in your mouth?..______yes______no
Do you have bad breath?..______yes______no
Have you ever had any serious problem associated with previous dental treatment?..............______yes______no
If yes, please explain:____________________

____

How often do you brush your teeth?____________________
What type of toothbrush do you use? ( ) manual ( ) electric ( ) both
If electric, what kind? ( ) Sonicare ( ) Oral-B/Braun ( ) Interplak ( ) Other____________________
What texture of brush do you use? ( ) soft ( ) medium ( ) hard ( ) nylon ( ) natural
How often do you floss? ( ) once per day ( ) once per week ( ) once per month ( ) rarely
Do you use anything else besides a toothbrush and/or floss?.. ______yes______no
If so, what? ____________________
Do your gums bleed when you brush?.. ______yes______no
Do your gums bleed when you floss?.. ______yes______no
Do you avoid brushing any part of your mouth because of pain?..______yes______no
If so, what part?____________________
Do your gums feel tender or swollen?...______yes______no
Have you ever had orthodontic treatment?...______yes______no
If so, do you still wear a retainer(s)?..______yes______no
Do you have any problem chewing your food?..______yes______no
Do you clench or grind your teeth together while sleeping or during the day?.......................______yes______no
Do your jaws ever feel tired?..______yes______no
Do your jaws ever lock open... ______yes______no
Does your bottom jaw click or pop when you open or close?...______yes______no
If so, do you have any pain when this occurs?..______yes______no
Have you lost teeth?...______yes______no
Missing teeth replaced by:

a. fixed bridge.. ______yes______no
b. removable partial denture(s)................( ) upper ( ) lower..............................______yes______no
c. full denture(s)....................................( ) upper ( ) lower.............................______yes______no

Have you discussed replacement(s) with your dentist?..______yes______no
If so, what type of replacement(s) have been discussed?
( ) fixed bridge(s) ( ) implant(s) ( ) removable partial denture(s)
Do you usually have cavities?..______yes______no
Do you lose fillings or break fillings?.. ______yes______no
Are you pleased with the appearance of your teeth?...______yes______no
How do you feel about your teeth in general?____________________

____

____

____

Please add anything you feel is important:____________________

____

____

____

____

GEORGE D. PYLANT III, DDS

Practice Limited to Periodontics

3001 Brown Trail, Suite 104
Bedford, Texas 76034
Metro(817)577-1077

PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I authorize and consent to Dr. Pylant's office sharing my health information with any treating physician and any health insurance company that insures me/patient. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by Dr. Pylant's office of its *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Dr. Pylant's office has the right to change its *Notice of Privacy Practices* at any time and that I may contact Dr. Pylant's office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that Dr. Pylant's office restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Dr. Pylant's office is not required to agree to my requested restrictions, but if Dr. Pylant's office does agree then Dr. Pylant's office is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:____

Signature:____

Relationship to Patient:______________________________________

Date:____