# Conroe Dental Associates

Welcome and thank you for selecting our dental healthcare team! We strive to provide you with the best possible dental care. To help us become better acquainted, please fill out this form completely in ink and sign all the pages. If you have any questions or concerns, please let us know.

**PATIENT INFORMATION (CONFIDENTIAL)**

Full Name _____ What would you like us to call you? _____ Sex: M / F

Street Address _____ City _____ State _____ Zip _____

Birthdate _____ Social Security # _____ Drivers License #_____

Home Phone _____ Work Phone _____ Mobile _____

Email _____ Whom may we thank for referring you? _____

Employer Name (Patient/Parent's) _____ Employer's Address _____

Insurance Company Name _____ (please provide card to receptionist)

Main reason for your visit today? _____

What would you like to accomplish today? _____

Previous Dentist _____ Date of last visit _____

To help us make your visit more comfortable, please let us know the following about your previous dental visits:

What you liked most _____ What you liked least _____

_____ _____

**PARENT** (for minors) / **SPOUSE INFORMATION** (please fill out completely)

| MOTHER/WIFE | | FATHER/HUSBAND | |
|---|---|---|---|
| NAME: | | NAME: | |
| ADDRESS: | | ADDRESS: | |
| CITY, STATE, ZIP: | | CITY, STATE, ZIP: | |
| WORK PH: | CELL: | WORK PH: | CELL: |
| DL#: | DOB: | DL#: | DOB: |
| SS#: | | SS#: | |

Person Financially Responsible: _____

Please list any of your family members who are patients in our office _____

| YES | NO | PATIENT DENTAL HISTORY |
|---|---|---|
| | | Do yours gums bleed when you brush? |
| | | Do you feel pain in any of your teeth? |
| | | Are you interested in straight teeth in only 6 months? |
| | | Do you grind your teeth at night? Do you have joint/jaw pain? |
| | | Do you snore or gasp for air at night when you sleep? Are you tired all the time? |

The following questions help us determine what is important to you. On a scale of 1 to 5 (1 not important/low, 5 most important/high) please rate:

| | |
|---|---|
| How healthy would you like your mouth to be? | 1 2 3 4 5 |
| How do you feel your overall dental health is? | 1 2 3 4 5 |
| How preventative (or proactive) would you like to be regarding your dental health? | 1 2 3 4 5 |
| What is your level of sensitivity or anxiety to dental procedures? | 1 2 3 4 5 |
| How important are dental cosmetics to you? | 1 2 3 4 5 |
| How do you feel about your smile and the look of your teeth? | 1 2 3 4 5 |

I authorize Conroe Dental Associates to release any information including diagnosis and the records of any treatment or examination rendered to me or my child to third party payers and/or health practitioners. I agree to be responsible for payment of all services rendered on my behalf or for my dependents.

Name _____ Signature of patient _____

(or parent if patient is a minor)

Conroe Dental Associates

## HEALTH INFORMATION

Medical Physician _____ Office Phone _____ Last Visit _____
Are you under medical care now? (If so, please describe) _____
Please list any medications you are taking _____
Do you use tobacco products? (Re: cigarettes, smokeless tobacco) _____

Do you have or have you had any of the following health problems? All information is confidential and helps us determine what medicines and treatments are best for you. (Be sure to fill chart out completely)

| YES | NO | | YES | NO | |
|---|---|---|---|---|---|
| | | Diabetes | | | Organ Transplant |
| | | Rheumatic Fever | | | Joint Replacement or Implant |
| | | Heart Murmur | | | Radiation Treatment |
| | | Valve Disorders | | | Stroke |
| | | Heart Trouble, Heart Attack | | | Anemia |
| | | Heart Disease | | | Frequently Tired or Easily Winded |
| | | Cardiac Pacemaker | | | Liver Disease |
| | | High or Low Blood Pressure (Please Specify) | | | Ulcers, Stomach or Mouth |
| | | Asthma | | | Respiratory Problems, Tuberculosis |
| | | Hepatitis (Specify A, B or C) Year: | | | Eye or Ear Problems |
| | | Frequent Illness, Lowered Immunity | | | Epilepsy or Seizures |
| | | Bleeding Disorder, Hemophilia | | | Unusual Weight Loss or Gain |
| | | Blood Transfusions Reason | | | HIV + AIDS |
| | | Cancer, Tumors, Cysts | | | Other: |

**ALLERGIES**

| YES | NO | | YES | NO | | PLEASE LIST ANY OTHER ALLERGIES: |
|---|---|---|---|---|---|---|
| | | Penicillin | | | Iodine | |
| | | Local Anesthetics | | | Latex Rubber | |
| | | Aspirin | | | Sulfa Drugs | |
| | | Codeine | | | | |

Is there any other health information we should know?

Are you Pregnant? YES / NO Due Date _____ Nursing? YES / NO Oral Contraceptives? YES / NO
(Please inform us if you become pregnant.)

Please inform us if your health information should change in any way.

Whom should we contact in case of an emergency? (PLEASE DO NOT LEAVE THIS BLANK)
Name_____Phone_____Relationship_____
Closest relative or friend not living with you?_____ Phone _____

To my knowledge the above information is correct and complete. I understand that providing incorrect information can be dangerous to my health. If the patient is a minor, permission is hereby given for dental treatment as deemed necessary to be performed in our office or until written notice is given discontinuing this permission. I agree to be financially responsible for all expenses incurred for myself or my dependents.

Signature _____ Date _____

Conroe Dental Associates
CHRISTOPHER BURTON, D.D.S.
333 N. Rivershire Suite 280
Conroe, TX 77304
936-756-9884

## NOTICE OF PRIVACY PRACTICES

**OUR LEGAL DUTY:**

Our office is required by law to maintain the privacy of your health information, to give you notice about how we do this and what your rights are.

**HOW WE USE YOUR HEALTH INFORMATION:**

We use your health information for treatment, payment and healthcare operations.

This means - We may discuss your health information with another doctor or healthcare worker involved in your treatment. We may use this information to obtain payment for your treatment from third parties such as insurance companies. We may also use this information for our internal operations such as training and quality assessment and to contact you about appointments using phone, mail or email.

You have the right to decide who else, by specific signed authorization, has access to your health information such as family members, employers, marketing companies or other entities not directly related to our office or your treatment.

We must disclose your health information when required to do so by law or if we believe your health or safety or the health or safety of someone else is threatened.

**YOUR RIGHTS:**

You may request, in writing, a copy of your health information. We may charge a reasonable fee for this service. Upon request, a more detailed and lengthy explanation of our policies is available.

Questions and Complaints - If you have any issues concerning the privacy of your health information, you may direct your complaints to the contact person listed below. You may also submit a written complaint to the US Dept. of Health and Human Services.

Contact Officer:
Christopher Burton, DDS
(936)756-9884
Email: chrisburtondds@gmail.com
333 N. Rivershire Dr. Suite 280
Conroe, TX 77304

Thank you for helping our office comply with federal law on health information privacy policies.

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## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I,_____, have received a copy of this office's notice of privacy practices.

Please Print Your Name: _____

Signature _____ Date _____

Please give us as much notice as possible if you cannot make it to a scheduled appointment so that we may offer the appointment to another patient. If you cancel an appointment less than one full business day in advance, you may be charged a $40 cancellation fee. Thank you for your help with this matter.

For office use only: We attempted to obtain written acknowledgment of our Notice Of Privacy Practices but could not because - Individual refused to sign, communication barriers existed, an emergency situation (circle one) or other reason _____