R. MARK BLACKMORE, DDS
General and Cosmetic Dentistry
9901 VALLEY RANCH PKWY EAST, SUITE 1001 | IRVING, TX 75063 | (972)869-4683

TODAYS DATE____________________

PATIENT INFORMATION

NAME_______________________________ DATE OF BIRTH______________ EMAIL___________________________

ADDRESS____________________________________ CITY____________________ STATE______ ZIP_____________

GENDER ❑ M ❑ F ❑ MARRIED ❑ WIDOWED ❑ SINGLE ❑ MINOR ❑ SEPARATED ❑ DIVORCED

SOCIAL SECURITY NUMBER _______-_______-__________ DRIVER'S LICENSE NUMBER_______________________

OCCUPATION_____________________ EMPLOYER____________________ EMPLOYER PHONE (____) ______________

HOME PHONE (_____) ____________ CELL PHONE (_____) ______________ BEST WAY TO CONTACT? _______________

WHOM MAY BE THANK FOR REFERRING YOU? _________________________

EMERGENCY CONTACT____________________ PHONE (____) ______________ RELATIONSHIP TO PATIENT _____________

RESPONSIBLE PARTY
-IF DIFFERENT FROM ABOVE-

PERSON RESPONSIBLE FOR THIS ACCOUNT_____________________________ RELATIONSHIP TO PATIENT______________

ADDRESS _________________________________ HOME PHONE (____) ___________ CELL PHONE (____) ____________

DATE OF BIRTH ______________ EMPLOYER _________________________ EMAIL ___________________________

CURRENTLY A PATIENT IN OUR OFFICE? ❑ YES ❑ NO

INSURANCE INFORMATION

SUBSCRIBER NAME ____________________________________ RELATIONSHIP TO PATIENT_________________________

DATE OF BIRTH ________________ POLICY ID NUMBER _____________________________ SSN _______-________-________

EMPLOYER ____________________________________ INSURANCE PROVIDER _______________________________

GROUP NUMBER ______________________ PHONE NUMBER OF INSURANCE PROVIDER (____)__________________

DENTAL HISTORY

REASON FOR TODAYS VISIT ____

DATE OF LAST DENTAL CARE ________________________________ DATE OF LAST DENTAL XRAYS _________________

DATE OF LAST DENTAL CLEANING _____________________________ DO YOU HAVE A FEAR OF DENTISTRY? ❑ YES ❑ NO

✓ IF YES, PLEASE EXPLAIN____

CHECK ( ) IF YOU HAVE HAD ANY OF THE FOLLOWING:

❑ BAD BREATH
❑ BLEEDING GUMS
❑ CLICKING OR POPPING JAW
❑ FOOD COLLECTION BETWEEN TEETH
❑ GRINDING TEETH
❑ LOOSE TEETH OR BROKEN FILLINGS
❑ PERIODONTAL TREATMENT
❑ SENSITIVITY TO COLD
❑ SENSITIVITY TO HOT
❑ SENSITIVITY TO SWEETS
❑ SENSITIVITY WHEN BITING
❑ SORES IN MOUTH

HOW OFTEN TO YOU FLOSS? _____________________________ HOW OFTEN DO YOU BRUSH? ____________________

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MEDICAL HISTORY

Are you currently under the care of a physician? ☐ YES ☐ NO Please explain: ____________________

☐Yes ☐ No Do you require premedication prior to dental appointments?
☐Yes ☐ No Are you pregnant? Week #____
☐Yes ☐ No Are you nursing?
☐Yes ☐ No Are you taking any prescription, over-the-counter or herbal supplement drugs?

Please list any prescriptions, over-the-counter or herbal drugs:

____
____
____
____

Are you allergic to any of the following?

☐ Aspirin ☐Latex
☐ Codeine ☐Metals
☐ Dental Anesthetics ☐Penicillin
☐Sulfa

Please list any other drug/ material allergies:

____
____
____
____

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

☐ Abnormal Bleeding
☐ Alcohol/ Drug Abuse
☐ Anemia
☐ Arthritis/Rheumatism
☐ Artificial Bone/ Joint/ Valve
☐ Asthma
☐ Blood Transfusion
☐ Cancer ____________________
☐ Chemotherapy
☐ Congenital Heart Defect
☐ COPD
☐ Diabetes
☐ Defibrillator
☐ Difficulty Breathing
☐ Emphysema
☐ Epilepsy
☐ Fainting
☐ Frequent Headaches
☐ Glaucoma
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis C
☐ Herpes or Fever Blisters
☐ High Blood Pressure
☐ HIV / AIDS
☐ Hospitalization
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Scarlet Fever
☐ Radiation Treatment
☐ Seizures
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tuberculosis

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

____
____

____________________ Signature of patient (or guardian)

____________________ Date

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Our entire staff is pleased that you have insurance benefits to help you and your family with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. With this in mind, please read the information on our insurance claims process so that we can work together to ensure benefits.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept most private insurance plans, which means that we work with hundreds of companies. Although we maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information that we have, but it is *only an estimate.*

I THOUGHT I PAID MY PORTION, BUT I RECEIVED A BILL. WHY?

We base the patient portion of your bill on our most current data, but there are several factors that can affect this estimate. For example, there may be a deductible, or you may have received treatment in another office prior to joining our office. Insurance companies do not inform us of any charges to your benefits. We do, however, investigate your benefits as thoroughly as possible.

FINANCIAL OPTIONS

We request payment for your portion at the time service is rendered. We do have several methods of payment that are designed to help you and your family gets the quality of care that you deserve. Please feel free to ask any staff member if there is anything that we can do to serve you.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile that you deserve.

I have read, understand and accept the terms of the above outline policies for insurance handling and financial commitments that I may incur as a result of treatment.

____ Signature of patient (or guardian if minor)

________________________ Date

HIPPA Law

I understand that according to the Federal HIPPA Law that this office is unable to discuss my treatment, account balance or any other matters pertaining to me unless I indicate that they may do so.

I agree that the following people can be informed of any association that I may have with this office including but not limited to treatment, diagnosis, financial arrangement, account balances and my general well-being:
Please list below:

1. ____
2. ____

This consent applies until I ask that a name be deleted or a new form replaces this one.

____ ____________________________

Signature of patient (or guardian if minor) Date

FINANCIAL

I acknowledge full responsibility for the payment of all services rendered on my behalf or my dependents. I understand that payment is **DUE AT THE TIME OF SERVICE**. I also understand that I am responsible for any fees that Dr. Blackmore incurs collecting the balance on my account including collection companies, court costs, etc.

I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me.

I hereby authorize Dr. Blackmore or his designated staff to take radiographs, study models, photographs and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs and that these records may be used for diagnostic and educational purposes.

Upon such diagnosis, I authorize Dr. Blackmore to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I hereby authorize Dr. Blackmore to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care.

I grant the right to Dr. Blackmore to release my dental, medical, and other information about my dental treatment to third party payers and/or other health professionals, as appropriate under the circumstances.

I grant the dental office permission to use the email address given to contact me with respect to my dental care.

I acknowledge that there is a cancellation fee for any appointment cancelled with less than 24 hours notice.

I have read all the information on the office policy letter and this sheet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or any changes in the above information.

____ _______________________

Signature of patient (or guardian if minor) Date