7820 Eldorado Pkwy, Suite 150
McKinney, TX 75070
Phone: (945) 224 0070
Fax: (945) 240 0080
Email: Outlookdent@gmail.com

We warmly welcome you to our office. Please take a few moments to complete the following information so that we can better care for you. It is our goal to help you reach and maintain maximum oral health.

Circle one: Mr. Mrs. Dr. Ms. Miss

Name: _____

I prefer to be called: _____ Male Female

Birth date: _____ SSN: _____

Home address:_____

_____

Hm # _____ Cell #_____

Wk. # _____ PGR # _____

Email _____

How do you prefer to confirm your appointments?

_____

Employer: _____

_____

Occupation: _____

Whom may we thank for referring you? _____

Other family members seen by us?

_____

Previous / Present Dentist: _____

Date of Last Visit : _____ Ph# _____

Physician's Name: _____

Phone: _____

Address: _____

Dental Insurance

Primary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

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

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Address: _____

Phone: _____

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

Insured's Name: _____

Relation: _____

Insured's Birth date: _____

Insured's SSN: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name:_____

Relation:_____

Wk # _____ Hm # _____

A note for patients with dental insurance – We will assist you to maximize your insurance benefits, and we are happy to file claims to your insurance carrier and agree to accept payment from any carrier that offers an assignment of benefits, if you desire. We will do our best to calculate your available benefit amount, however, regardless of what your insurance plan pays, you are responsible for all fees.

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Medical History

Your current physical health is: Good Fair Poor

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

If yes, please explain: _____

Are you taking any prescription/over the counter drugs? Yes No

If yes, please list: _____

Do you use or smoke tobacco in any form? Yes No

Have you or do you take Redux/Fen Phen or Pondimin? Yes No

For women: Are you taking birth control pills? 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?

Y	N	Abnormal Bleeding	Y	N	Herpes/Fever Blisters
Y	N	Alcohol/Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+/AIDS
Y	N	Angina Pectoris	Y	N	Hospitalized Any Reason
Y	N	Arthritis	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Latex Allergy
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusions	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Colitis	Y	N	Nervous/Anxious
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Shingles
Y	N	Frequent Headaches	Y	N	Sinus Problems
Y	N	Glaucoma	Y	N	Stroke
Y	N	Hay Fever	Y	N	Thyroid Problems
Y	N	Heart Attack	Y	N	Tumors
Y	N	Heart Murmur	Y	N	Ulcers
Y	N	Heart Surgery	Y	N	Venereal Disease
Y	N	Hemophilia	Y	N	Yellow Jaundice
Y	N	Hepatitis			

Do you or have you used bisphosphonate medication (Fosomax, Actonel, Boniva, Skelid, Didronel, Aredia, Zometa, Bonefos)? If yes, Which_____ Y N

Do you have, or have you had any disease, condition, or problem not listed above?:

_____

_____

Are you allergic to any of the following items?

Y	N	Aspirin	Y	N	Latex
Y	N	Codeine	Y	N	Penicillin
Y	N	Dental Anesthetics	Y	N	Tetracycline
Y	N	Erythromycin	Y	N	Other

Please list any other drugs you are allergic to:

Dental History

Why have you come to the dentist today? _____

_____

Are your teeth sensitive to: Heat Cold Pressure Sweets

Do you have any fear of dental work? Yes No What work was done at your last dental office visit? _____

_____

How do you feel about the appearance of your teeth? _____

_____

How would you describe the condition of your teeth and gums?

Good Fair Poor

Are you currently in pain or discomfort with your teeth or gums?

YesNo If yes, please explain: _____

How often do you brush your teeth? _____ Floss? _____

Do your gums bleed when you brush? YesNo

Do your gums bleed when you floss? YesNo

Have you ever experienced pain in you jaw joint? Yes No

Have you ever been treated for TMJ symptoms? Yes No

If yes, please explain: _____

Do you grind or clench your teeth? Yes No

1. The undersigned hereby authorizes doctor to order x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me, and to use the appropriate medication and therapy indicated for such treatment in connection with the patient named on this form. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1½ % finance charge (18% APR) may be added to my account, in addition to any collection charges.
4. I understand that where appropriate, credit bureau reports may be ordered.
5. I understand that it is my responsibility to advise your office of any changes in the information obtained.
6. I authorize the use of my social security number to file my dental claims.

Medical History/Consent

Patient Signature: _____ Date _____

Doctor Signature: _____ Date: _____

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Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1.) I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan.

2.) I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors, but copies of certain aids are available upon request for a fee.

3.) In general terms, the dental procedure(s) can include but not limited to:

A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.

B. Application of resin "sealants" to the grooves of the teeth.

C. Treatment of diseased, or injured teeth with dental restorations (fillings).

D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or Infections

4.) I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, during treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service.

5.) I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

6.) I have answered all the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____ _____

PATIENT NAME DATE OF BIRTH

_____ _____

PARENT/GUARDIAN IF PATIENT IS A MINOR RELATIONSHIP TO PATIENT

_____ _____

SIGNATURE DATE

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PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the "Notice of Privacy Practices" and have been provided an opportunity to review it. Copy of Notice of Privacy Practice is available on request.

Patient full name: _____

Date of birth: __/__/_____

Parent/ Guardian: _____

Signature: _____

Date: __/__/_____

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PHOTO CONSENT FORM

Patient Name: _____ Date: _____

I consent for medical photographs to be taken of me by Dr.Patel and , or a representative of the staff at Outlook Dental in Mckinney. I understand that the information may be used in my dental records for purposes of demonstration and teaching, as well as:

1) Kept on record for future treatment
2) Electronically emailed to my treating health professional
3) Used by physician for education and training
4) Paper or electronic health publications
5) Available for marketing materials

By consenting to these photographs, I understand that I will not receive payment from any party. Although these photographs will be used without identifying information such as my name or personal information, I understand that it is possible that someone may recognize me. Refusal to consent to photographs will in no way affect the dental care that I will receive. If I wish to withdraw my consent in the future, I may do so with a written request.

I authorize the use of these image: (**Please initial indicating YES or NO below**)

_____ YES _____ NO For demonstration purposes including an office photo album.

_____ YES _____ NO On our website for prospective patients.

_____ YES _____ NO In print advertisements and/or professional journals.

By signing this form below, I confirm that this consent form has been explained to me in terms which I understand.

_____ _____
Patient Name Printed/ Date Patient Signature

_____ _____
Witness Name Printed/ Date Witness Signature

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Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office a 48-hour advanced notice if you need to reschedule your appointment. This allows time for another patient to be scheduled into that available time.
If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A fee of $50.00 will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.**
No future appointments can be scheduled nor can records be transferred without the payment of this fee.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Outlook Dental Appointment Cancellation Policy.

_____

Patient Signature Date