



PATIENT INFORMATION (CONFIDENTIAL)

NAME _____ DATE _____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
E-MAIL _____ HOME PHONE _____ CELL PHONE _____
CHECK APPROPRIATE BOX: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED
SOC. SEC. # _____ BIRTHDATE _____
PATIENT'S OR PARENT'S EMPLOYER _____ WORK PHONE _____
SPOUSE OR PARENT'S NAME _____ EMPLOYER _____ WORK PHONE _____
WHOM MAY WE THANK FOR REFERRING YOU? _____
PERSON TO CONTACT IN CASE OF AN EMERGENCY _____ PHONE _____

RESPONSIBLE PARTY

PERSON RESPONSIBLE FOR THIS ACCOUNT _____ RELATIONSHIP TO PATIENT _____
ADDRESS _____ HOME PHONE _____
DRIVER'S LICENSE _____ BIRTHDATE _____ SOC. SEC. _____ EMPLOYER _____
_____ WORK PHONE _____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? YES NO

INSURANCE INFORMATION

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL# _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
INSURANCE CO. _____ TEL # _____ GRP # _____ POLICY / ID # _____
INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING:

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____
BIRTHDATE _____ SOCIAL SECURITY NUMBER _____ DATE EMPLOYED _____
NAME OF EMPLOYER _____ UNION OR LOCAL# _____ WORK PHONE _____
EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____
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INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOW MUCH IS YOUR DEDUCTIBLE? _____ HOW MUCH HAVE YOU USED? _____ MAX ANNUAL BENEFIT? _____

HEALTH QUESTIONNAIRE

Today's Date _____

Patient's Name _____

Birthdate _____

Name of person completing this form (if different from patient) and relation to patient:

_____ Relationship: _____

Please answer the following questions to the best of your ability, realizing that true and accurate answers are important to the delivery of quality care. **All information you provide will be kept confidential.**

**** PLEASE ANSWER BY CHECKING OR CIRCLING Yes (Y) OR No (N) FOR EACH QUESTION ****

1. Are you in good health? Y N
2. Has there been any change in your general health in the past year? Y N
3. Date of last check up by physician: _____
4. Are you currently under a physician's care? Y N
If so, what for? _____
Treating Physician's Name: _____ Phone Number: _____
5. Have you had any serious illness, operations, or hospitalizations? Y N
If so, describe and give approximate dates:

6. Have you ever had intravenous sedation or general anesthesia? Y N
Were there any adverse effects? _____
7. Do you generally tolerate dental treatment well? Y N

DO YOU HAVE OR HAVE YOU EVER HAD:

- A. Heart disease that was detected at birth? Y N
- B. Rheumatic fever or Rheumatic heart disease? Y N
- C. Cardiovascular disease (chest pain, heart trouble, heart attack, coronary artery disease, high blood pressure, stroke, palpitations, heart surgery, angioplasty, pacemaker)? Y N
- D. Lung disease (asthma, emphysema, chronic cough, bronchitis, pneumonia, TB, shortness of breath, severe cough)? Y N
- E. Neurologic Disorders (seizure, epilepsy, fainting, dizziness, nervous disorder)?..... Y N
- F. Blood Disease (bleeding disorder, anemia, blood transfusion, do you bruise easily)? Y N
- G. Liver Disease (jaundice, hepatitis)? Y N
- H. Kidney Disease? Y N
- I. Diabetes? Y N
- J. Thyroid Disease (hypothyroidism, tumor)? Y N
- K. Arthritis? (which joints) Y N
- L. Stomach ulcers or intestinal problems? Y N
- M. Glaucoma? Y N

- N. Frequent or recurring mouth sores? Y N
- O. Implants/artificial joints anywhere in your body? (heart valve, hip, knee) Y N
- P. Radiation (x-ray treatment for cancer) in head and neck region? Y N
- Q. Noises in jaw joint, pain near ear when chewing, do you grind or clench teeth? Y N
- R. Sinus or nasal problems? Y N
- S. Any disease, drug or transplant operation that has depressed your immune system? Y N
- T. Recurrent infections of any kind? Y N
- U. Cancer? Y N

ARE YOU TAKING OR USING ANY OF THE FOLLOWING:

- A. Antibiotics? Y N
- B. Anticoagulants (blood thinners)? Y N
- C. Thyroid medications? Y N
- D. Antihistamines, decongestants? Y N
- E. High blood pressure or heart medication? Y N
- F. Steroids? Y N
- G. Tranquilizers, Antidepressants? Y N
- H. Stomach or GI medications (antacids, etc.)? Y N
- I. Cholesterol reducing drugs? Y N
- J. Aspirin, ibuprofen, NSAIDS or anti-inflammatory drugs, narcotics or other pain relievers? Y N
- K. Weight reduction pills or diet aids (over the counter or “natural” products)? Y N
- L. Vitamins, natural remedies (ginko biloba, ephedra, ginseng, etc.) or other supplements? Y N
- M. Marijuana, cocaine or other “recreational” drugs? Y N
- N. Any other regular medications, pills, supplements or drugs? Y N
- O. Bisphosphonates for osteoporosis? Which kind? _____ Y N
- P. IV Bisphosphonates – Aredia or Zometa? Y N

PLEASE LIST ALL CURRENT MEDICATIONS HERE

ARE YOU ALLERGIC TO OR HAD A BAD REACTION FROM:

- A. Local anesthetic (Novocain-like drugs)? Y N
- B. Penicillin, Amoxicillin, Cephalosporins? Y N
- C. Other antibiotics? Y N
- If so, please list: _____
- D. Barbiturates, sedatives? Y N
- E. Aspirin, ibuprofen, NSAIDS, or other pain medications? Y N
- F. Codeine or other narcotics or opioids? Y N
- G. Latex? Y N

H. Other allergies or reactions? Y N
Please list:

GENERAL HEALTH:

- A. Do you have hay fever, frequent skin rashes, etc.? Y N
- B. Do you use alcohol? How much per day? _____ Y N
- C. Do you smoke? Y N
What product and how many per day? _____ For how long? _____
- D. Do you spit tobacco?For how long? _____ Y N
- E. Are you, or have you been, in a drug or alcohol recovery program? Y N
- F. Do you have any other disease, condition or problem not listed above that you think the doctor should know about (please describe in the comments below) ? Y N
- G. Do you wish to talk to the doctor privately about anything? Y N
- H. Any additional comments? Y N

WOMEN

- A. Are you taking birth control pills? Y N
- B. Are you pregnant, trying to become pregnant or any chance you might be pregnant? Y N
- C. Are you BREAST FEEDING? Y N
- D. Are you taking hormone replacement? Y N

I UNDERSTAND THE IMPORTANCE OF A TRUTHFUL HEALTH HISTORY AND REALIZE THAT INCOMPLETE INFORMATION MAY HAVE AN ADVERSE EFFECT ON MY TREATMENT. TO THE BEST OF MY KNOWLEDGE, THE INFORMATION ABOVE IS COMPLETE AND ACCURATE.

Date Signature of person completing Patent Information & Health History

Thank you: Do not write below this line.

Medical update: I have reviewed my health history dated ___/___/___ and confirm that it accurately states past and present conditions.

Exceptions: _____

Date Signature of person completing Health Update

OUR POLICY OF CARE AND PAYMENT

Ensuring that our patients receive high quality care is the goal of our practice:

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive the maximum allowable benefits. In order to achieve these goals, we need your assistance in understanding of our payment policy.

Payment is due at the time of treatment. We accept cash, check, and major credit cards. We also have a payment plan called CareCredit, that allows you to start treatment today and spread payments over time.

Applying for CareCredit only takes a few minutes and there is no fee to apply.

We will file with your insurance company. A deposit may be required on all scheduled surgeries unless other arrangements have been made and approved by our financial administrator.

We will gladly discuss your proposed treatment and answer any questions regarding relating to your insurance. You must realize, however, that:

- 1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.**
- 2) Our fees generally fall within the acceptable range by most companies and therefore covered up to the maximum allowable determined by each carrier. This applies to companies who pay a percentage (such as 50% or 80%) of UCR, which is defined as usual and customary rates.**
- 3) Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services that are not covered.**

We must emphasize that as dental care providers, our relationship is with you, not your insurance company. While the filing of the claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the service is rendered.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask. We are here to help YOU.

Signature

Date

Syed A. Khalid, DDS, MS
Practice Limited to
Periodontics & Dental Implants



Phone: (281) 427-5118
Fax: (281) 428-8529
4450 Baytown Central Blvd.
Baytown, TX 77521

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. 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 received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Private Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry our treatment, payment, or healthcare options. I also understand you are not required to agree to my restrictions, but if you do agree than you are bound to abide by such restrictions.

Signature: _____ Date: _____

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We will file with your insurance company. A deposit may be required on all scheduled surgeries unless other arrangements have been made and approved by our financial administrator.

We will gladly discuss your proposed treatment and answer any questions regarding relating to your insurance. You must realize, however, that:

- 1) Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.**
- 2) Our fees generally fall within the acceptable range by most companies and therefore covered up to the maximum allowable determined by each carrier. This applies to companies who pay a percentage (such as 50% or 80%) of UCR, which is defined as usual and customary rates.**
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