Welcome New Patients!

Thank you so much for selecting my office as a provider for your dental health care needs. I look forward to getting acquainted with you soon! As a new patient there is some necessary information that I will need to obtain from you prior to your appointment. Following these easy steps should make the process go smoothly. ☺

1. Please **print and complete** the Patient Registration & Health History forms, bringing them with you to your dental appointment. These should be completed prior to your arrival at our office**. If it is not possible for you to complete these before you arrive, please arrive an extra 10-15 minutes BEFORE your appointment time** in order to complete the necessary paperwork and registration.

2. If you have Dental Insurance – We will be happy to file your insurance claim for you, and will accept Assignment of Benefits for the estimated portion that your carrier will cover, but to do so we must verify your insurance a few days prior to your appointment. At the time you called our office to schedule your visit, we should have obtained your insurance information but if we failed to do so please notify us 1-2 business days before your visit. If you are uncertain, please call our office (972) 221-9136 prior to your appointment to verify we have received all necessary information and that your dental insurance has been confirmed.

3. **On the day of your visit**: Office Services, Deductibles and/or Co-Payments are due at the time of your visit and can be made by Visa, MasterCard, Discover, American Express, CareCredit, Personal Check or Cash. Please bring the completed Patient Registration Forms, and your dental insurance card and present it to the receptionist upon arrival. If you do not have a dental insurance card, please let us know. **Be prepared that even with Dental Insurance Benefits, there may be a Deductible and/or Patient Co-Payment that will be due at the time of treatment.**

4. Important – Please bring any current dental x-rays to assist us with your dental treatment. You will need to pick up your x-rays or have them mailed to us from your previous Dentist. (For consideration, "Current X-rays" are: Full Mouth Series or Panoramic Films, taken within the past 3 years; Bitewing/Cavity Check Xrays, taken within the past 12 months.

6. If you will be more than 10 minutes late for your appointment, please call our office to verify that your appointment can still be accommodated.

We are looking forward to meeting you and helping you with your dental needs.
Thank You.

Rex Alan Payne, D.D.S.
Lewisville Dental Associates, P.A.

Patient Information

Name_____ Date_____
First MI Last (Preferred Name)

Address_____

City_____ State _____ Zip_____

Mobile # _____ Home_____ Work _____

Birth date _____ Male___ Female___ Social Security Number_____

Email Address_____ Drivers Lic #_____

Single ____ Married ____ Widowed ____ Divorced ____

Patient employed by_____Occupation_____

Business Address_____

Whom may we thank for referring you?_____

In case of emergency please contact_____

Phone _____ Relationship_____

Insurance Information

Insured/Person responsible for account_____

Relationship to the Patient _____Birth Date_____ Social Security #_____

Address (if different from patient) _____

City_____ State_____ Zip_____

Business /Employer Name _____

Insurance Company Name_____ Phone _____

Member ID #_____ Group/Plan #_____

Regarding Insurance:

If you have dental insurance, we will gladly file dental claims for your treatment once your coverage and benefits have been verified**. Your estimated co-pay and deductibles will be collected at each visit.** These numbers are only **estimates**, as your insurance company is unable to provide exact information to us because your insurance policy is a contract between you, your employer and your insurance company. We are not a party to that contract. Regardless of what the insurance policy pays or does not pay, I understand that I am fully responsible for any unpaid balance not paid by my insurance. By signing below I agree to these terms.

I authorize my insurance company to make payments directly to **LEWISVILLE DENTAL ASSOCIATES** on my behalf for treatment rendered. I fully understand that quoted costs are **estimates** only, and the patient portion may change if treatment changes or, if the insurance pays more or less than estimated.

Signature of Patient/Parent or Guardian _____ Date: _____

Patient Health History:

Patient Name _____ Date of Birth: _____

Are you currently under the care of a physician?_____ If YES, please explain: _____

_____

Name of Physician: _____ Phone: _____

List any surgeries: _____

_____

I am currently taking the following medications and/or supplements:

_____ _____

_____ _____

_____ _____

Have you ever had any complications following dental treatment?_____

Are you on blood thinners?_____ If YES, please list: _____

Are you allergic to any of the following?

☐ Latex ☐ Metals ☐ Penicillin ☐ Codeine ☐ Sulfa ☐ Local anesthetics ☐ Other _____

WOMEN - Are you: ☐ pregnant or trying to get pregnant ☐ nursing ☐ on oral contraceptives

Have you ever had/or currently have the following:

☐ Joint Replacement/Implant	☐ Been told to Pre-Medicate before dentistry	☐ Heart Valve Replacement
☐ AIDS/HIV	☐ Suppressed Immune System	☐ Heart Stent
☐ Organ Transplant	☐ Endocarditis	☐ Repaired congenital heart defect
☐ Rheumatic Fever	☐ Mitral Valve Prolapse	☐ Heart Murmur

Do any of the following apply to you:

☐ Use of tobacco in any form	☐ Prolonged UV light exposure (i.e. tanning beds, sun, etc.)
☐ Alcohol use	☐ HPV infection (human papillomavirus)

Medical Health History:

Patient Name _____ Date of Birth: _____

	Cancer/tumors
	Chemotherapy or Radiation Treatments
	Asthma or Breathing Difficulties
	Diabetes
	Kidney Disease or Renal Dialysis
	High Blood Pressure
	Stroke

	Pacemaker
	Heart Attack/failure
	Heart Surgery
	Hemophilia/Bleeds easily
	Blood transfusion
	Hepatitis A - B - C
	Artificial Joint Implants/Prosthetics

Please list any other serious medical conditions_____

Dental Health History:

	Bleeding gums
	Bad breath
	Dry Mouth
	Hot & Cold sensitivity
	Food catching between teeth
	Excessive bleeding after procedure

	Acid reflux
	Clenching or grinding teeth
	Soreness in jaw joint
	Fever blisters/canker sores
	Worn braces

Are you currently experiencing any dental problems?

_____

_____

What would you like to change about your smile? _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. To the best of my knowledge, all of the preceding answers and information provided are true and correct. Should any further health information be needed, I grant permission for Dr. Payne to ask the respective health care provider who may release such information. I will notify Dr. Payne of any changes or updates to my health and medications as such changes occur.

_____ _____ _____

Patient/Legal Guardian (Print Name) Patient/Legal Guardian Signature Date

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

Date: _____ Date: _____ Date: _____ Date: _____ Date: _____ Date: _____

*** To be initialed by the assistant, hygienist or dentist reviewing the health history with the patient.**

Form updated 07/09/2015

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patients of Lewisville Dental Associates, P.L.L.C.:

HIPPA is the Health Insurance Portability and Accountability Act. We are restricted from revealing to anyone that you or a member of your family is a patient or being treated in our office without your consent. This restricts us from: Sending your impression(s) and/or dental appliance(s) for fabrication and/or repairs to our laboratory and technicians; Presenting your checks to the bank or processing your credit card payment; Referring or sharing treatment information, models, diagnostic records, and or copies of dental x-rays with other healthcare providers to include, but not limited to your personal physician, orthodontist, oral surgeon, etc.; Filing and processing an insurance claim with your insurance company; Making personal contact and confirming dental appointments with contact information that you have provided to us. This can include, but is not limited to postcard/mail, telephone, voice mail, e-mail, leaving messages with other person(s) at home or work number, etc.

Signing the HIPPA consent form will enable us to operate normally with the care and business activities of delivering dental services and establishing the framework for compliance with the act. We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of Lewisville Dental Associates, P.L.L.C. Notice of Privacy Practices.

_____

Please print your name here

_____

Signature *Date*

The following person(s) are allowed to pick up dental x-rays or other similar forms of health information on my behalf, and you may disclose any or all of my care with them.

Name	Relationship	Phone
Name	Relationship	Phone

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

Due to an emergency situation it was not possible to obtain an acknowledgement.

We weren't able to communicate with the patient.

Other *(Please provide specific details*_____

_____ _____

Employee signature *Date*

REX ALAN PAYNE D.D.S.

FAMILY DENTAL PRACTICE

Financial Agreement

1. I understand that **all deductibles and co-pays are due at the time of my appointment**. I understand any balances left on my account after insurance pays are my full responsibility.

    * We will gladly file dental claims as a courtesy to our patients. We will accept assignment for payment as long as the patient agrees to pay the balance after insurance has paid. We try our best to **estimate** co-pays & deductibles that are due; however, it is impossible for us to know every insurance plan. We ask our patients to be proactive in knowing how their insurance plan pays and if necessary, be willing to contact the insurance company on their own behalf in order to resolve a claim dispute.

2. There will be a $35 fee for returned checks. In the event of a returned check, I understand that I will no longer be able to pay by check in the future.

3. I understand that after 90 days, regardless of whether my dental insurance claim has been paid or not, my account must be paid in full. Any account left past due or unpaid will be subject to being turned over to a Collection Agency. If it becomes necessary to take these additional steps to collect, I understand that I will be held responsible for ALL costs incurred (i.e. collection fees, court costs, attorney fees, etc.) Further, I understand that by allowing my account to fall delinquent to these measures I may jeopardize and possibly sever my professional relationship with Dr. Payne.

4. I understand that when an appointment is made for me, the time is held specifically for me. I will give a 24 HOUR NOTICE if I need to cancel or change the appointment. If this notice is not given, I will be charged $35 for each appointment hour of time that was held for me or my family member(s).

**We accept Cash, Personal Checks with Proper ID, Care Credit*, and all Major Credit Cards for payment.

Patient/Parent Name (printed) _____

Patient/Parent Signature: _____

Date: _____

REX ALAN PAYNE D.D.S.

FAMILY DENTAL PRACTICE

Consent for Treatment

I hereby authorize Dr. Rex Payne or designated staff to take x-rays, study models, or other aids deemed appropriate by Dr. Rex Payne to make thorough diagnosis of my special dental needs.

Insurance companies may impose limits regarding the types and frequency in which some x-rays are taken. Regardless of insurance coverage, it is Dr. Payne's responsibility to provide a comprehensive evaluation to you, which cannot be done without the proper diagnostic tools available. Should my insurance company decline coverage for these x-rays I understand I will be responsible for the fees associated with the service.

If I decline the recommended x-rays, I understand that I will be required to sign a release of liability that states I fully understand that there are conditions that cannot be diagnosed without the proper x-rays and I will not hold Dr. Payne liable for any condition which may present itself and left undiagnosed without proper x-rays.

I have read the above information regarding x-rays and fully understand Dr. Payne's philosophy.

Patient or Guardian_____ Date _____

Upon examination and diagnosis, I authorize Dr. Payne to perform all recommended treatment mutually agreed upon by me, to employ proper care. I understand that Dr. Payne and/or designated staff will discuss home care instructions, complications and/or post-treatment needs. I also understand I can ask for complete explanation of any possible complications.

I agree to use anesthetic, sedatives and other medication as necessary. I understand anesthetic agents can have certain risks. If I am given a prescribed medication, I will take it as directed. I will consult with the pharmacist about drug interactions with other medications I may be currently taking. I also understand it is not advisable to operate a vehicle or hazardous device while taking prescribed pain medications.

If I elect to postpone or decline treatment that has been recommended by Dr. Payne, I understand that my future treatment can become more extensive, more costly, lead to tooth loss or contribute to other health problems.

Insurance may limit or exclude services they pay, but Dr. Payne will not dictate my level of care by these limitations.

Patient or Guardian _____Date _____