

Hagler-Sciarrilla Family Dentistry PLLC

www.haglerdds.com

1273 N Main St • Vidor, TX 77662

(409)769-3887

Medical History

Patient Name: _____
Last First M Preferred Name

DOB: _____

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response. If none of these apply to you, please check the very last box "None".

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> AFIB | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Acetaminophen Allergy |
| <input type="checkbox"/> Alzheimers Disease | <input type="checkbox"/> Amoxicillin Allergy | <input type="checkbox"/> Anemia | <input type="checkbox"/> Angina |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Arthritis/Gout | <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Augmentin Allergy | <input type="checkbox"/> Back/neck pain | <input type="checkbox"/> Blood Thinner |
| <input type="checkbox"/> Blood Tranfusion | <input type="checkbox"/> Bloody Sputum | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Bruise Easily |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Clindamycin Allergy |
| <input type="checkbox"/> Codeine Allergy | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Cortisone |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Medicine/Steroids |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Excessive Thirst | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Hepatitis A-Infectious | <input type="checkbox"/> Heart Surgery |
| <input type="checkbox"/> Hepatitis C | <input type="checkbox"/> Herpes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Ibuprofen Allergy | <input type="checkbox"/> Irregular Heart Beat | <input type="checkbox"/> History of Heart Attack |
| <input type="checkbox"/> Kidney/Liver Disease | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Keflex Allergy |
| <input type="checkbox"/> Low Blood pressure | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Lidocaine Allergy |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Penicillin Allergy | <input type="checkbox"/> Premed | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Rheumatism | <input type="checkbox"/> Psychiatric Care |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Sickle Cell Disease | <input type="checkbox"/> Sinus Troubles | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Stents | <input type="checkbox"/> Stroke | <input type="checkbox"/> Sulfa Allergy | <input type="checkbox"/> Sleep Apnea |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Use Tobacco - Dip | <input type="checkbox"/> Swelling of Limbs/Ankles |
| <input type="checkbox"/> Use Tobacco - Vape | <input type="checkbox"/> Vertigo/Dizziness/Fainting | <input type="checkbox"/> XNone | <input type="checkbox"/> Use Tobacco - Smoke |

Allergies NOT listed above:

If you checked "Osteoporosis" or "Osteopenia", what medication are you on and who is the doctor treating you:

Please list any recent/past surgeries or conditions we should be aware of:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: Yes No

Pre-Med:

Women: Are you...

On Birth Control Nursing Pregnant N/A

If you are pregnant, when is your due date and who is your doctor:

Name of your Physician - Phone Number:

Preferred Pharmacy - Location - Phone Number:

In an emergency, who should be notified? Please enter Name - Relationship - Phone number:

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications (MEDICATION NAME ONLY!! We will take note of dosage if necessary) below:

Yes No

Please list any medications you are currently taking, one medication per line:

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First M Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
_____ City State Zip Code

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Signature _____ Date _____

Signature _____ Date _____

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Patient Name: _____
Last First M Preferred Name

DOB: _____

HIPAA Acknowledgement

NOTICE OF PRIVACY PRACTICES

Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below you acknowledge that we have given you a copy of our Notice of Privacy Practices.

USE AND DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

REQUESTING A RESTRICTION ON THE USE OR DISCLOSURE OF YOUR INFORMATION

You may request restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to our request, the restriction will be binding with our office. Use or disclosure of protected information in violation of Federal privacy standards.

REVOCACTION OF CONSENT

You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient:

Who is filling out this form?

Self Parent Legal Guardian Spouse Grandparent

Name of person filling out this form (if other than patient): _____

I understand the above information and agree with its contents of the HIPAA Disclosure Form.

Signature _____ Date _____

Staff signature:

Signature _____ Date _____

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Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____
Last First M Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ____-____-____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

Whom may we thank for referring you to our practice?

Referral Name: _____

Responsible Party Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or you are the parent/guardian of the patient.

The following is for: the patient's spouse the person responsible for payment both neither-not applicable

Name: _____
Last First M Preferred Name

Title: _____ Gender: Male Female Family Status: Married Single Child Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS#: ____-____-____ DL#: _____

Email Address: _____ Best time to call: _____

Phone: _____
Home Mobile Work Ext Fax Other

Address: _____
Address 1 Address 2
City State Zip Code

Employment Information

The following is for: the patient the person responsible for payment both not applicable

Employer Name: _____ Phone: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Primary Dental Insurance:

Name of Insured: _____
Last First M

Insured's Birth Date: _____

ID #: _____ Group #: _____

Insured's Address: _____
Address 1 Address 2

City State Zip Code

Insured's Employer Name: _____

Employer Address: _____
Address 1 Address 2

City State Zip Code

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Insurance Address: _____
Address 1 Address 2

City State Zip Code

Insurance Company Phone Number:

Insurance Authorization:

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of my electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

Consent for Services and Financial Policy

WELCOME TO OUR PRACTICE

Thank you for choosing our office for your dental care. We value your trust and are committed to providing exceptional treatment in a professional and friendly environment. This information outlines our financial policies, scheduling guidelines, and other important office procedures to help avoid misunderstandings.

FINANCIAL POLICY:

Payment is due when services are rendered. Our financial manager will review your fees before you see the doctor. We want you to feel confident that you understand your treatment costs and are receiving the best value for your care.

If you have dental insurance, your treatment plan is an estimate of your cost after what we are expecting your plan to cover. This estimate is not a guarantee of payment from your insurance company. Any amount not covered by your insurance-whether due to deductibles, plan limitations, exclusions, frequency limits, or non-covered services-is your responsibility.

It is your responsibility to: provide current and accurate insurance information at each visit, inform us immediately of any changes to your insurance plan, and pay for all charges incurred if your insurance is not one we are able to file.

We make every effort to verify your insurance prior to your appointment; however, there are times when a patient's insurance changes without notice. If we provide treatment and later learn that your insurance is inactive or not accepted by our office, you will be responsible for the full balance.

You will receive a detailed itemization of charges at each visit. We recommend keeping these for your records. If your account is paid in full, you will be given an appointment card for future visits. If you anticipate difficulty paying in full, please speak with our staff before your appointment. All financial arrangements are kept confidential.

ACCEPTED FORMS OF PAYMENT:

We accept Cash, Check, Visa, Mastercard, Discover, American Express, and CareCredit. Payment can also be made by phone with a credit or debit card.

DIVORCE:

Divorce is a legal matter between spouses and does not affect your financial responsibility to our office. Federal and state laws supersede divorce decrees; therefore, divorce does not cancel responsibility for your minor children's treatment costs.

MISSED APPOINTMENTS & CANCELLATION POLICY:

We understand that emergencies and unexpected situations arise. If you are unable to keep an appointment, please call at least 24 hours in advance to reschedule or cancel. Reschedules/Cancellations with less than 24 hours' notice or failure to show will result in a \$25 fee per hour scheduled. This fee is not billable to insurance and must be paid before your next visit. Patients with two or more late cancellations or no-shows may be dismissed from the practice.

MINOR CHILDREN:

For patients 17 years old or younger, a parent or legal guardian must be present at the appointment unless we have a signed letter of authorization on file. This letter must grant permission for us to treat the child without the parent/guardian present. Please note: stepparents, siblings, grandparents, and other relatives are not considered legally responsible unless they are the child's legal guardian.

We appreciate your cooperation and thank you for choosing our office. If you have any questions about these policies, please ask a member of our team-we are happy to help.

I understand the above information and agree with its contents of the Consent for Services and Financial Policy.

Signature _____ Date _____

Response Date: _____