matthew horne
Family & Cosmetic Dentistry DDS

Driver's License # _____ Date _____

1. **Patients's Name** _____ Preferred Name _____
   Last First Middle
2. Address _____
   Street City State Zip Code
3. Home Phone _____ Birth Date _____ Social Security # _____
4. E-mail Address _____ Cell Phone _____ Work Phone _____

5. **Person Responsible for Payment** _____
   Last First Middle
6. Address _____
   Street City State Zip Code
7. Relationship to Patient _____
8. Social Security # _____
9. Birth Date _____
10. Driver's License # _____
11. Home Phone _____
12. Employer _____
13. Work Phone _____

If minor, list parent's names:

Father _____
First Last

Mother _____
First Last

14. **Patient's Spouse Name** _____
    Last First Middle
15. Spouse's Employer _____
16. Occupation _____
17. Work Phone _____

DENTAL INSURANCE INFORMATION (need copy of card)

18. Insured's Name _____
19. Insured's Birth Date _____
20. Insured's Address (if different from above) _____
21. Insured's Social Security # _____
22. Insured's Employer _____
23. Insurance Company Name _____ Group # and Member ID # _____
24. Insurance Address and Phone # _____

EMERGENCY INFORMATION

25. Local Friend or Relative not living with you _____
26. Complete Address _____
27. Phone Number _____

GETTING TO KNOW YOU

28. Why did you select our office? _____
29. Whom may we thank for referring you? _____
30. Is another member of your family or relative a patient in our practice? _____

FOR ALL PATIENTS

I authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above and further authorize and consent that the doctor chooses and employs such assistants as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

PRIVACY POLICY

☐ **I have chosen NOT to receive a copy of the privacy policy. I understand a copy is available at any time on the website www.TheAustinDentist.com**

Patient's, Parent's or Guardian's Signature **Date**

Our Financial Policy

Thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you. As you know, our office and health care providers continue to struggle trying to get insurance companies to pay us in a timely manner. In order for us to provide the best service possible, we find ourselves having to make some hard insurance decisions. As a result, we implemented a new Financial Policy, which we require that you read, and sign prior to any treatment.

INSURANCE COVERAGE

Our office is happy to cooperate with patients who are covered by dental insurance. We ask that you familiarize yourself with your policy and be aware of any limitations that might exist. Having dental insurance means that you have an agreement with your insurance company regarding payment for dental procedures. There are varying dental levels that are available with a given insurance company. How well your plan pays will be based on what level plan of insurance you have purchased. We will file your primary insurance claim for you to help you obtain the reimbursement with which you are entitled. If your insurance company does not cover all costs, it will become your responsibility to make final payment.

PAYMENTS

Payment is due at time of service less your estimated insurance benefit. You may use cash, check, credit card or debit card to pay. Payment arrangements may be requested in cases of financial hardship through Care Credit. Except when financial arrangements have been made before hand, accounts that are 60 days past due will be billed 1.5% interest on the total unpaid balance. Accounts that are 90 days past due will be referred to a third-party collection agency and all associated fees will be passed on to patient.

INSURANCE PAYMENTS

Your insurance is a contract between you and your insurance company. We are not a party in this contract. Be assured, our office works diligently to obtain payment from your insurance company. However, if we file your insurance, and the claim has not been paid for any reason within 60 days, we require that you pay the balance using one of the approved payment methods without exception. In the event that your insurance pays us after that time, you will be reimbursed.

CONSENT FOR PROCEDURE

I certify that all of the medical and dental information I have provided is true and accurate to my knowledge and I have not eliminated any pertinent information. I consent to the performing of any dental examinations and treatment procedures agreed to be necessary or advisable, including anesthesia, nitrous oxide, or oral sedation, as indicated. A separate consent will be obtained for any surgical procedures. I understand that I will be informed of any treatment changes as they occur. I also understand that I am responsible for all fees associated with all procedures and all costs incurred in the collection of those fees, even if I am covered under a dental insurance policy.

EMERGENCY FIRST-TIME VISITS

Emergency first-time visits, we require payment in full of either cash or credit card prior to being seen.

MISSED/LATE-CANCELLED APPOINTMENTS

Our office requires a 48-hour notice during **business hours** for any rescheduling or cancellation of appointments. An appointment which is cancelled or failed without 48-business-hour notice will allow our office to charge $75.00 broken appointment fee. Please note, cancellations are not accepted by email, text or voicemail. ☐ **I have read and accept the cancellation and missed appointment policies.**

RETURNED CHECKS

Our bank charges us whenever a patient presents a check that does not have funds available. Therefore, we must charge you a **$35.00** handling fee. Payment plus the handling fee will be due immediately, and we will request that future visits be paid with cash, credit or debit card.
We welcome the opportunity to discuss any aspect of our financial policy. Please ask to speak to our office manager or assistant manager if you have any questions, comments, or concerns. We sincerely regret having to create such a policy and hope you understand our reasoning. We thank you for your support, and look forward to serving you in the future.

PATIENT AUTHORIZATION

☐ I have read, understand, and agree to abide by the terms stipulated above. I request that payment of benefits be made to Matthew Horne, DDS. I hereby authorize the release of any information necessary to determine liability for payment and obtain reimbursement on any claim. This authorization shall remain valid until revoked by me in writing.

Patient Name_____

Patient Signature *(or Parent of minor/Legal Guardian):* ✗ _____ Date:_____

Name of person completing form if other than patient:_____ Relation:_____

DENTAL HISTORY

How would you rate the condition of your mouth? ❑ Excellent ❑ Good ❑ Fair ❑ Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/_____
Date of most recent treatment (other than cleaning) ___/___/_____
I routinely see my dentist every: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? Scale of 1 (least) to 10 (most): _____ ❑ ❑
2. Have you ever had an unfavorable dental experience? ❑ ❑
3. Have you ever had complications from past dental treatment? ❑ ❑
4. Have you ever had trouble getting numb or reactions to local anesthetic? ❑ ❑
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? ❑ ❑
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma? ❑ ❑

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? ❑ ❑
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? ❑ ❑
9. Have you ever noticed an unpleasant taste or odor in your mouth? ❑ ❑
10. Is there anyone with a history of periodontal disease in your family? ❑ ❑
11. Have you ever experienced gum recession? ❑ ❑
12. Are your teeth becoming loose on their own (without an injury), or do you have difficulty eating an apple? ❑ ❑
13. Have you ever experienced a burning sensation in your mouth? ❑ ❑

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? ❑ ❑
15. Does the amount of saliva in your mouth ever feel too little or do you have difficulty swallowing any food? ❑ ❑
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? ❑ ❑
17. Are any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth? ❑ ❑
18. Do you have grooves or notches on your teeth near the gum line? ❑ ❑
19. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling? ❑ ❑
20. Do you frequently get food caught between any teeth? ❑ ❑

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, or popping) ❑ ❑
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together? ❑ ❑
23. Do you / would you have any problems with chewing bagels, baguettes, protein bars or other hard food? ❑ ❑
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn)or has your bite changed? ❑ ❑
25. Are your teeth becoming more crooked, crowded, or overlapped? ❑ ❑
26. Are your teeth developing spaces or becoming more loose? ❑ ❑
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together? ❑ ❑
28. Do you place your tongue between your teeth or close your teeth against your tongue? ❑ ❑
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? ❑ ❑
30. Do you clench or grind your teeth together in the daytime or make them sore? ❑ ❑
31. Do you have any problems with sleep or wake up with an awareness of your teeth? ❑ ❑
32. Do you wear or have you ever worn a bite appliance? ❑ ❑

SMILE CHARACTERISTICS

33. Is there anything about the appearance of your teeth that you would like to change? ❑ ❑
34. Have you ever whitened (bleached) your teeth? ❑ ❑
35. Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? ❑ ❑
36. Have you been disappointed with the appearance of previous dental work? ❑ ❑

Patient's Signature _____ **Date** _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Preferred Name _____ Age_____

Name of Physician/and their specialty _____

Most recent physical examination_____ Purpose _____

What is your estimate of your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury	❑	❑
2. allergic reaction to		
❑ aspirin, ibuprofen, acetaminophen		
❑ penicillin		
❑ erythromycin		
❑ codeine		
❑ local anesthetic		
❑ fluoride		
❑ metals (gold, stainless steel)		
❑ latex		
❑ any other medications_____		
3. heart problems or cardiac stent within last 6 months	❑	❑
4. history of infective endocarditis	❑	❑
5. artificial heart valve, repaired heart defect (PFO)	❑	❑
6. pacemaker or implantable defibrillator	❑	❑
7. orthopedic implant (joint replacement)	❑	❑
8. rheumatic or scarlet fever	❑	❑
9. high or low blood pressure	❑	❑
10. a stroke (taking blood thinners)	❑	❑
11. anemia or other blood disorder	❑	❑
12. prolonged bleeding due to a slight cut (INR>3.5)	❑	❑
13. emphysema, sarcoidosis	❑	❑
14. tuberculosis, measles, chicken pox	❑	❑
15. asthma	❑	❑
16. breathing or sleep problems (i.e. snoring, sinus)	❑	❑
17. kidney disease	❑	❑
18. liver disease	❑	❑
19. jaundice	❑	❑
20. thyroid, parathyroid disease, or calcium deficiency	❑	❑
21. hormone deficiency	❑	❑
22. high cholesterol or taking statin drugs	❑	❑
23. diabetes (HbA1c=_____)	❑	❑
24. stomach or duodenal ulcer	❑	❑
25. digestive disorders (i.e. gastric reflux)	❑	❑

	YES	NO
26. osteoporosis/osteopenia (taking bisphosphonates)	❑	❑
27. arthritis	❑	❑
28. glaucoma	❑	❑
29. contact lenses	❑	❑
30. head or neck injuries	❑	❑
31. epilepsy, convulsions (seizures)	❑	❑
32. neurological problems (attention deficit disorder)	❑	❑
33. viral infections and cold sores	❑	❑
34. any lumps or swelling in the mouth	❑	❑
35. hives, skin rash, hay fever	❑	❑
36. STD / HPV / STI	❑	❑
37. hepatitis (type___)	❑	❑
38. HIV / AIDS	❑	❑
39. tumor, abnormal growth	❑	❑
40. radiation therapy	❑	❑
41. chemotherapy	❑	❑
42. emotional problems	❑	❑
43. psychiatric treatment	❑	❑
44. antidepressant medication	❑	❑
45. alcohol / drug dependency	❑	❑
ARE YOU:		
46. presently being treated for any other illness	❑	❑
47. aware of any change in your general health	❑	❑
48. taking medication for weight management	❑	❑
49. taking dietary supplements	❑	❑
50. often exhausted or fatigued	❑	❑
51. experiencing frequent headaches	❑	❑
52. a smoker or smoked previously	❑	❑
53. considered a touchy / sensitive person	❑	❑
54. often unhappy or depressed	❑	❑
55. easily upset or irritated	❑	❑
56. FEMALE: taking birth control pills	❑	❑
57. FEMALE: pregnant	❑	❑
58. MALE: prostate disorders	❑	❑

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List any medications, supplements, and or vitamins taken within the last two years

DRUG	PURPOSE	DRUG	PURPOSE

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ **Date** _____

Doctor's Signature _____ Date _____