PATIENT INFORMATION

Contact Information

Mr. ☐ Mrs.☐ Miss ☐ Patient's Last Name: _____First Name: _____MI: ____

Home Phone ( ) _____Cell ( ) _____Work ( ) _____ Ext: _____
Home Address_____
Street City State Zip
Date of Birth _____/_____/_____ Social Security #_____

Email Address _____

Whom may we thank for referring you? _____

Place of Employment _____

Employer's Address _____
Street City State Zip

Occupation _____

Emergency Contact Name/Number(s)_____

Financial Information

Name of person responsible for this account_____Relationship _____

Street Address _____Phone ( ) _____
Street City State Zip
Date of Birth _____/_____/_____ Social Security # _____ Drivers License #_____

Place of Employment _____Work Phone ( ) _____

Employer's Address _____
Street City State Zip

Is this patient currently a patient in our office Yes ☐ No ☐

Dental Insurance Information

Insured Person's Full Name_____

Date of Birth ___/_____/____Social Security # _____ Address _____

Relationship to Patient (i.e. parent, spouse): _____Ins. Phone Number: ( )_____

Insurance Company Name: _____Group ID Number: _____

Insurance Company Mailing address for Dental Claims: _____

Employer Name: _____Employer Address: _____

Sarah J. Morris, DDS PLLC

HEALTH QUESTIONAIRE

(This information is necessary for dental treatment and is strictly confidential)

Patient Name_____
Name of Physician _____ Date of last physical _____/_____/_____
City _____Physician's phone number: ( ) _____
Pharmacy and phone number_____ ( ) _____

Are you allergic to: **Penicillin:** **YES/NO** **Codeine:** **YES/NO**
Local Anesthetics: **YES/NO** **Latex:** **YES/NO**

Other known allergies: _____
Have you had any illnesses, i.e. AIDS, HIV, drug or transplant operation that has **depressed your immune system?**
YES/NO If yes:_____
Do you have Hepatitis: YES/NO If yes, which type? _____
Have you ever had any prosthetic joint replacements? (Hips, shoulders, knees, etc.) YES/NO
If yes, please provide type and date placed: _____ _____/_____/_____
Do you need to take **PRE-MEDICATION** prior to dental visits? YES/NO
If yes, please explain:_____
Do you have a heart murmur or mitral valve prolapse? YES/NO
Do you wish to speak privately with Dr. Morris about anything? YES/NO

Please list any and all medications you are currently taking and the reasons you are taking those meds:
_____
_____
_____
Please list any other medical condition or **recent surgeries** you feel Dr. Morris should be aware of:
_____
_____

Please answer all by circling yes or no

Heart Problems	Y	N	Nervous Problems	Y	N	Adenoids Removed	Y	N
High Blood Pressure	Y	N	Tuberculosis	Y	N	Tonsils Removed	Y	N
Low Blood Pressure	Y	N	Excessive Bleeding	Y	N	Asthma	Y	N
Circulatory Problems	Y	N	Cerebral Palsy	Y	N	Venereal Disease	Y	N
Rheumatic Fever	Y	N	Scarlet Fever	Y	N	Fainting/Nervous	Y	N
Diabetes	Y	N	Malignancies/Cancer	Y	N	TMJ/ Locking Joint	Y	N
Radiation Treatments	Y	N	Chronic Ear Problems	Y	N	FEMALES		
Epilepsy	Y	N	Anemia	Y	N	Are you pregnant?	Y	N
Kidney Problems	Y	N	Arthritis	Y	N	Are you nursing?	Y	N

I hereby acknowledge that I have provided the above health information to Dr. Sarah Morris and that it is true and accurate.

_____/_____/_____
Patient Signature or Guardian Relationship Date

Sarah J. Morris, DDS PLLC

DENTAL QUESTIONAIRE

Name_____ DOB____/_____/_____

How can we help you today? _____

Name of previous dentist: _____ City/State: _____

Date of last visit: _____/_____/_____Reason for last visit: _____

Are you sensitive to Hot: _____ Cold: _____ Sweets: _____ Chewing/Pressure: _____

Have you had any injuries to the mouth/jaw area? _____

When were your last dental x-rays? ____/_____/____When was your last cleaning and exam? _____/_____/____

Do your gums bleed or feel tender? YES/NO

Did your previous dentist recommend a 3 or 4-month checkup? YES/NO
If yes, please explain:
_____

Do you smoke or use tobacco products? YES/NO

Are you aware of grinding or clenching your teeth? YES/NO

Do you have discolored teeth that bother you? YES/NO

Are there any dental concerns you would like Dr. Morris to be aware of? _____
_____

I hereby acknowledge that I have provided the above dental information to Dr. Sarah Morris and that it is true and accurate.

_____/_____/_____
Patient Signature or Guardian Relationship Date

Consent for Services

I hereby 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 named above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedures involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also understand and agree that any all past due balances over thirty days will be subject to a 1.5% finance charge per month as allowed by Texas state law.

_____/_____/_____
Signature of Patient or Responsible Party Date

Sarah J. Morris, DDS PLLC

SERVICE ACKNOWLEDGMENT

Assignment of Insurance Benefits

In consideration of services rendered, I hereby transfer and assign to Sarah J. Morris, DDS PLLC, 2551 River Park Plaza Suite 210, Fort Worth, Texas, 76116, all right, title and interest in any payment due for services as provided in the policy or policies of dental insurance held by me.

I agree to pay, at Fort Worth, Tarrant County, Texas the charges of Sarah J. Morris, DDS PLLC, which exceed the amount paid by the insurance policies held by me. I further agree and authorize Sarah J. Morris DDS PLLC, to release any information requested by the insurance company(s) or its representatives. *I understand that filing of my dental insurance is done as a courtesy to me.*
Initials: _____

Agreement to Pay for Services Rendered
I agree to pay for all services rendered by Sarah J. Morris DDS PLLC. I further understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance. I also understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge as allowed by the laws of the State of Texas.
I acknowledge that I have received a copy of the Notice of Privacy Practices (HIPAA).
Initials: _____
I agree to allow Sarah J. Morris, DDS PLLC and her employees to use any photographs of any portion of my dental treatment for the purpose of teaching, in dental publications and in any medium including but not limited to the internet. I have been advised that no identifying information is ever attached to any photograph.

Initials: _____

I hereby authorize Sarah J. Morris DDS PLLC, to release dental information regarding myself by mail, on my answering machine or voice mail.

Initials: _____

I hereby authorize Sarah J. Morris DDS PLLC, or her employees to telephone me at home, on my cell or at my work to discuss any aspect of my dental treatment.

Initials_____

I hereby authorize Sarah J. Morris, DDS PLLC to release dental information regarding myself by to the following individuals:

Initials _____

Name/Relationship_____

I have read the above conditions of treatment and payment and agree to their content.

_____

Print Name of Patient

_____/_____/_____

Signature of patient, parent, or guardian: Date

Financial Policy for Our Patients

We do not participate in any DMO/HMO dental plans or reduced fee schedule plans.

Our office understands the value of dental insurance and will file dental claims on your behalf. We will accept your assignment of *your* benefits – this means that you must agree to "assign" your benefits to us so that we may receive payment from your dental insurance carrier. We will complete and process all insurance claims forms for you.

Most dental insurance plans ***do not*** cover 100% of the cost of your treatment. Because of this, and a delay in receiving payment from the insurance company, you will be asked to pay your deductible as well as your ***estimated*** portion of your charges the day services are rendered.

We will estimate as closely as possible your coverage, but until we actually receive payment from your insurance carrier, it is just that- an estimate. If we do not receive payment from your carrier with 30 days, the entire balance is due from you.

Please understand that we file and accept assignment of your insurance benefits as a courtesy to you. If your insurance denies coverage or does not pay *for any reason,* you are ultimately responsible for any and all charges incurred in our office.

Payment Options

Our office accepts cash, personal checks and all most credit cards for services. We do not finance any dental work ourselves. For those patients who require a little extra time to pay for services, we work very closely with CareCredit. Our office does offer a payment plan through CareCredit. We offer a 3 month, no interest option as well as a 24, 36, and 48 month extended payment plan options. CareCredit's interest rate is 11.9% on extended plans. CareCredit can be reached at 800-839-9078 for further questions.

Please be advised that we do charge a fee for all failed and cancelled appointments without 24 hours notice

Initials _____

HIPAA

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 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 (insurance companies)
* conduct normal healthcare services

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notice of Privacy Practices prior to signing this consent. 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 below to obtain a current copy of the Notice of Privacy Practice.

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

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Signature: _____

Date: _____