AFFINITY SMILES
DENTAL
FAMILY AND COSMETIC DENTISTRY

1112 N. Highway 377, Suite 106
Roanoke, TX 76262
(817) 490-1775 phone
(817) 490-5053 fax

Dear ____________________________________

Welcome to Affinity Smiles Dental. We are very pleased that you have selected us for your dental care. Enclosed are forms for you to complete in advance of your appointment, which will assist our team in making sure we have all the information necessary to provide you with quality care. Please fill out the forms completely. If you have any questions or problems filling out the forms, do not hesitate to call so that we may assist you. Please bring your completed forms, insurance card(s) and photo ID to our office on the day of your appointment. You will be contacted prior to your appointment to make sure you don't have any questions or concerns.

Our office hours are by appointment:

Monday 9am to 6pm
Tuesday 8am to 5pm
Wednesday 9am to 6pm
Thursday – Closed
Friday 7am to 4pm
Saturday (2nd & 4th) 8am to 1pm

For dental emergencies after hours, please call 817-490-1775; you will then be directed to our after hour cell phone.

Help us to help you more efficiently:

- If you are ill, call as early in the day as possible so that we can accommodate you promptly.
- Let us know if you change your address, insurance or telephone number.
- If you are unable to make an appointment, please give us 48 hours notice. Chronic missed appointments could result in being dismissed from the practice.
- We take care of all paperwork and payment prior to treatment day; this will allow our team to prepare for your upcoming appointment.

Once again, welcome to Affinity Smiles Dental. We look forward to providing you with quality care.

Best Regards,

Dr. Nathan Ho and Dr. Chuong Do
Affinity Smiles Dental

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Patient Information

First Name:______________________________Last Name:______________________________Middle Initial: ________

Preferred Name: _______________________________

Address: ____

City, State, Zip: ____

Home Phone: ____________________Work Phone: ____________________Cell Phone: ____________________

○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Date of Birth: __________________ Social Security #: __________________________ Driver License #: _______________

E-mail: ____

Responsible Party

☐ **Same as Patient Information** *(If different, please complete section below)*

First Name:______________________________Last Name:_____________________________________

Address: ____

City, State, Zip: ____

Home Phone: ____________________Work Phone: ____________________Cell Phone: ____________________

Date of Birth: __________________ Social Security #: __________________________ Driver License #: _______________

E-mail: ____

Emergency Contacts

Name ____

Home Phone ___________________________ Cell Phone ________________________

Relationship ____

Name____

Home Phone: __________________________ Cell Phone: ________________________

Relationship: ____

Physician Name ____

Phone Number ____

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Patient Name ______________________________ Date of Birth ______________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Medical History

Are you under a physician's care now?	Yes	No	If yes, please explain: ______________________
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: ______________________
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: ______________________
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: ______________________
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: ______________________
Are you Pregnant/Trying to get pregnant?	Yes	No	
Taking oral contraceptives?	Yes	No	
Nursing?	Yes	No	

Are you allergic to any of the following?

Aspirin **Penicillin** **Codeine** **Acrylic** **Metal** **Latex** **Local Anesthetics**

Other If yes, please explain: ____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: ______________________

____

____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ______________________________ **DATE** ____________

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Patient Name ____ **Date** ____________________

Please provide a copy of all Insurance Card(s) and a Driver's License / Photo ID
You may be asked to present your insurance card(s) at each visit so that we can confirm that all information in our files remains current.

FINANCIAL POLICY AND PAYMENT GUIDELINES

Payment is due at the time of service. This includes all co-pays, deductibles and co-insurance.

- We accept Cash, MasterCard, Visa, Discover, Lending Club and Care Credit as payment for services rendered. We do not accept personal checks or American Express as a method of payment.
- I understand that payment prior to the treatment day will be requested. This will allow our team to prepare for your upcoming appointment.
- I understand that in the event I do not cancel my appointment within 48 hours of the scheduled appointment that the practice may charge a cancellation fee.
- I authorize direct payment of my insurance benefits to Affinity Smiles Dental for services rendered to myself or dependents.
- Insurance will be filed for services rendered. Any charges for services not covered by insurance will be the responsibility of the patient or his/her guardian. I understand that it is my responsibility to know my insurance benefits and whether or not the services rendered are covered benefits.
- Patient or guardian is responsible for notifying our office of any changes to demographics or insurance and billing information.
- Out of Network services not paid by the dental insurance will be the responsibility of the patient or his/her guardian.
- Affinity Smiles Dental or its authorized agent will provide dental information to the insurance company as required for payment of claims for services rendered.

Initials ______________

LATE / CANCELLATION / NO SHOW POLICY

We understand that delays can happen; however, we must keep the other patients and providers on time. If a patient is **15** minutes past the scheduled appointment time, we may need to reschedule the appointment.

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from obtaining needed treatment.

We request that you give our office 48 hour notice in the event you need to cancel or reschedule your appointment. If you do not contact our office, we consider this to be a No Show appointment.

Excessive cancelled appointments may result in you being dismissed from the practice.

If we do not receive a call 48 hours in advance, you may be charged a no show fee of $50.00. More than three no shows may result in you being dismissed from the practice.

As a courtesy, we provide an appointment card, a reminder call, text messages, and/or email for appointments. If you do not receive your reminder call or message, the cancellation guideline will still remain in effect. You are responsible for remembering your appointment. If you have any questions regarding these guidelines, please let our team know and we will be glad to provide clarification.
I have read and understand the Late / Cancellation / No Show Policy and agree to the terms.

Initials ________________

PRESCRIPTION DRUG POLICY / MEDICATION REFILL

Prescriptions will not be called in after normal business hours, on holidays or weekends when the doctor does not have your records. An early refill on your pain medicine will NOT be granted if you take more than the prescribed amount. Prescriptions will not be refilled if you have cancelled your last appointment, did not show for your last appointment, if you do not follow through with recommended treatment, you have been discharged from the practice, or if you were to return only as needed.

Please contact your pharmacy for medication refills. Your Pharmacy will fax us a medication refill request which the dentist will review. Refill authorizations may require 48-72 hours. Please allow sufficient time for us to process your refill request.

Pharmacy Name__________________________________ Address or Cross Street____

I have read and understand the Prescription / Medication refill policy. **Initials** ________________

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PRIVACY PRACTICES

Our office, physicians and staff, are committed to securing the privacy of your health information. We are making available to you a copy of our Notice of Privacy Practices.

Signature ____ **Date** ______________________

OPTIONAL AUTHORIZATION FOR RELEASE OF DENTAL INFORMATION TO OTHERS

☐ Do Not Release Information

I authorize Affinity Smiles Dental and its representatives to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my dental care, appointments, billing information, and insurance. This authorization will remain in effect until I provide written notification to Affinity Smiles Dental of changes or update.

Name ______________________________ Relationship ____________________ Phone ________________________

You may release the following information to the person named above: ☐ Appointments ☐ Billing Information ☐ Dental Care ☐ Leave Message

Name ______________________________ Relationship ____________________ Phone ________________________

You may release the following information to the person named above: ☐ Appointments ☐ Billing Information ☐ Dental Care ☐ Leave Message

Initials ______________

CONSENT FOR TREATMENT, RELEASE OF INFORMATION, AUTHORIZATION & ASSIGNMENT OF BENEFITS

- I consent to treatment necessary to the care which has been discussed and directed by the provider.
- I authorize the release of all medical records to specialists and/or consulting physicians if applicable to my care and condition.
- I authorize any holder of dental or other information about me to release to the insurance carrier any information needed for this or any other related claim to be processed. I permit a copy of this authorization to be used in place of the original and request payment of dental insurance benefits either to me or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any party who may be responsible for paying for my treatment.
- I further authorize and request that insurance payments be directed to Affinity Smiles Dental.

Initials ______________

Authorization to Treat a Minor (Ages 0-18th Birthday)

☐ **Not Applicable (patient is an adult)**

If there are circumstances when I am unable to bring my child to the office for his/her evaluation and treatment, I give my permission and authorization for the following persons (over the age of 18) to obtain medical care for my child. I also authorize the providers of Affinity Smiles Dental to discuss or disclose information regarding any matters relating to my child's appointment, insurance, test results or dental care to those listed below. This authorization will remain in effect until I provide written notification to Affinity Smiles Dental of changes or update. I authorize Affinity Smiles Dental to use the additional contact information listed below to discuss or disclose information regarding any matters relating to my appointments, insurance, billing information, test results and/or dental care.

Name ___________________________________ Relationship__________________ Phone_________________________

Name ___________________________________ Relationship__________________ Phone_________________________

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Patient's Name: ________________________________ ___ **Date** ____________________

Dental History

Your goal for today: ____

When was your last dental cleaning? ________________Year(s)/Months Ago

Your previous dental experiences were: Excellent Great Okay Bad

If you had a bad experience, please explain: ____

Do your gums bleed when you brush or floss?	Yes	No
Are your teeth sensitive to sweets or hot/cold drinks?	Yes	No
Do you currently have dental pain?	Yes	No

Smiles Analysis

Would you like to have whiter teeth?	Yes	No
Do you have prior dental work that appears unnatural?	Yes	No
Are you self-conscious about your teeth or smile?	Yes	No
Would you like to change anything about the appearance of your teeth or smile?	Yes	No

I am interested in the following

___ Exam/X-rays/routine cleaning ___ Crown(s) ___ Traditional Braces ___ Smile Makeover
___ Deep Cleaning ___ Implant(s) ___ ClearCorrect ___ Veneers
___ Filling(s) ___ Teeth Whitening ___ Cosmetic Consultation

How did you hear about our office?

___ Google ___ Yahoo ___ Website ___ ZocDoc
___ Postcard ___ Door Hanger ___ Our sign ___ Insurance
___ Coupon ___ Business Card ___ Other
___ Patient Referral; who may we thank for referring you? ____

I would like appointment reminders by

___ Text Messages to cell phone ________________________________
___ Emails to ____
___ Phone call to phone number ________________________________