

Office Policies

Please read, initial each section, and sign below.

_____ **PAYMENT:** Payment in full is expected at the time services are rendered. We accept cash, checks, MasterCard, VISA, Discover, and CareCredit. A returned check fee of \$30.00 will be assessed for any check payment that is returned due to insufficient funds. Subsequently, payment options for patients or accounts with returned items may be limited to cash or credit card.

_____ **DENTAL INSURANCE:** If we agree to accept assignment of benefits from a dental insurance company, patients must pay for any portion of the charges not covered as services are rendered. If payment for any dental claim is not received within 45 days, you will receive a statement for the entire balance due. If payment is not made within 45 days of receipt of the statement, your account may be turned over to collections. Charges that are denied or not covered by the insurance company are the responsibility of the patient or guardian.

_____ **COLLECTION COSTS:** Account balances more than 45 days past due may be sent to collections. Patients will be responsible for costs of collections including, but not limited to, collection agency fees, attorney fees and court costs.

_____ **PATIENT AND INSURANCE INFORMATION:** The patient will be responsible for informing the office of any changes to the following: mailing address, phone numbers, emergency contact information, insurance plan information, and changes in medical history, including the list of medications you are currently taking.

_____ **BROKEN APPOINTMENTS:** A missed appointment or late cancellation charge of \$50/hour will be assessed for any appointment that is missed with the hygienist, and \$75/hour missed with the dentist for any appointment that is cancelled with less than 48 hours notice. If adequate notice is not received for a cancelled appointment and we are unable to appoint another patient, there will be a charge to the account. Our goal in reinforcing this policy is to accommodate all patients, especially in the event of a dental emergency

_____ **HIPAA:** I have reviewed and/or received a copy of the office's Notice of Privacy Practices.

_____ **QUESTIONS:** Open communication is an important part of ongoing treatment and is essential if we are to keep you well informed and happy with our services. If you have any questions regarding your bill or dental treatment, please ask for clarification or additional information.

_____ I understand that Texas law provides and I agree, that if any healthcare worker is exposed to my blood or other bodily fluid, to allow Sweta Tailor DDS PPLC (via a laboratory) to perform tests on my blood or other bodily fluid to determine the presence of any communicable disease, including but not limited to, hepatitis and human immunodeficiency virus (which is the causative agent of AIDS). I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Sweta Tailor DDS PLLC. I understand that the results of such tests do not become a part of my medical record and will be at no cost to the patient.

By signing below, I acknowledge that I have read, understood, and agree to the above office policies. I also understand that I am ultimately financially responsible for any balance on my account.

Signature: _____ Date: _____

Patient Name (printed): _____

Medical History

Name: _____ Date: _____

Primary Care Physician (medical): _____ Phone #: _____

Please list all medications you are currently taking (including over-the-counter):

- 1) _____ 2) _____ 3) _____
4) _____ 5) _____ 6) _____
7) _____ 8) _____ 9) _____

Allergies to medications: _____

Allergy to latex: Yes No

(Women) Are you pregnant? Yes Due Date: _____ No Nursing? Yes No

Are you taking birth control pills/hormone replacement therapy? Yes No

Please check if you have ever or now have any of the following:

<input type="checkbox"/> AIDS / HIV	<input type="checkbox"/> Circulatory Problems	<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Respiratory Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cortisone Treatments	<input type="checkbox"/> Hepatitis A / B (circle)	<input type="checkbox"/> COPD
<input type="checkbox"/> Arthritis, Rheumatism	<input type="checkbox"/> Congenital Heart Disease	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Emphysema
<input type="checkbox"/> Artificial Heart Valve	<input type="checkbox"/> Cough - persistent, or with blood	<input type="checkbox"/> Herpes	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Artificial Joint (circle) Knee / Hip Other: _____	<input type="checkbox"/> Diabetes <input type="checkbox"/> (Family History)	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stroke
<input type="checkbox"/> Asthma	<input type="checkbox"/> Epilepsy / Seizures	<input type="checkbox"/> Immunosuppressive Drugs	<input type="checkbox"/> Chemical Dependency
<input type="checkbox"/> Auto Immune Illness	<input type="checkbox"/> Fainting/Dizziness	<input type="checkbox"/> Infective Endocarditis	<input type="checkbox"/> Swelling of feet/ankles
<input type="checkbox"/> Back Problems	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Intestinal Disorder	<input type="checkbox"/> Thyroid Problems
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Dialysis	<input type="checkbox"/> Tobacco Habit
<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Problems: _____	<input type="checkbox"/> Kidney Transplant	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Chemotherapy	<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Radiation Treatment	<input type="checkbox"/> Heart Transplant	<input type="checkbox"/> Nervous Problems	<input type="checkbox"/> Venereal Disease
<input type="checkbox"/> Surgery		<input type="checkbox"/> Pace Maker	<input type="checkbox"/> Psychiatric Care
		<input type="checkbox"/> Parkinson's	<input type="checkbox"/> Headaches (chronic)
		<input type="checkbox"/> CPAP (Sleep Apnea)	<input type="checkbox"/> Bisphosphonate Medication (for bones)

Please list any other medical conditions that we should be aware of: _____

Are you under the care of a specialist for any of these conditions? Yes No

Have you had any surgeries or hospital visits? Yes No (If 'yes', please specify with date) _____

To the best of my knowledge, all of the preceding information provided is true and complete. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ Date: _____

Office use only for future updates: To the best of my knowledge, all of the preceding information provided is true and complete. If I ever have any change in my health, I will inform the doctors at the next appointment.

_____ Date: _____
Signature of patient, parent or guardian

_____ Date: _____
Signature of patient, parent or guardian