

Welcome

Thank you for selecting our dental healthcare team!
We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL)

Patient # _____
SS#/SIN _____
Date _____
Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Divorced Widowed Separated
If Student, Name of School / College _____ City _____ State/Prov. _____ Full Time Part Time
Patient or Parent/Guardian's Employer _____ Work Phone _____
Business Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____
Whom May We Thank for Referring You? _____
Person to Contact in Case of Emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____
Address _____ Home Phone _____
Email _____ Cell Phone _____
Driver's License # _____ Birthdate _____ Financial Institution _____
Employer _____ Work Phone _____ SS#/SIN _____
Is this Person Currently a Patient in our Office? Yes No
For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.
 Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? Yes No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ SS#/SIN _____ Date Employed _____
Name of Employer _____ Union or Local # _____ Work Phone _____
Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____
Insurance Company _____ Group # _____ Policy/ID # _____
Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____
How Much is your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

- | | | | | | |
|--|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Are you under medical treatment now?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 9. Are you allergic to or have you had any reactions to the following? | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?..... | <input type="checkbox"/> | <input type="checkbox"/> | Local Anesthetics (e.g. Novocain)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, please explain _____ | | | Penicillin or any other Antibiotics..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sulfa Drugs..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | Barbiturates..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux?..... | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you use tobacco?..... | <input type="checkbox"/> | <input type="checkbox"/> | Iodine..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you use controlled substances?..... | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Are you wearing contact lenses?..... | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you have or have you had any of the following? | | | Latex Rubber..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | Yes | No | Other (please list)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| High Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Women Only: | | |
| Rheumatic Fever..... | <input type="checkbox"/> | <input type="checkbox"/> | a) Are you pregnant or think you may be pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles..... | <input type="checkbox"/> | <input type="checkbox"/> | b) Are you nursing?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting / Seizures..... | <input type="checkbox"/> | <input type="checkbox"/> | c) Are you taking oral contraceptives?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma..... | <input type="checkbox"/> | <input type="checkbox"/> | | Yes | No |
| Low Blood Pressure..... | <input type="checkbox"/> | <input type="checkbox"/> | Chest Pains..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy / Convulsions..... | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia..... | <input type="checkbox"/> | <input type="checkbox"/> | Stroke..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes..... | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever / Allergies..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases..... | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis..... | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection..... | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem..... | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Recent Weight Loss..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Liver Disease..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Heart Trouble..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Respiratory Problems..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Mitral Valve Prolapse..... | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other..... | <input type="checkbox"/> | <input type="checkbox"/> |

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

- | | | | | | |
|---|------------------------------|-----------------------------|--|------------------------------|-----------------------------|
| 1. Do your gums bleed while brushing or flossing?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> | 8. Do you have frequent headaches?..... | Yes <input type="checkbox"/> | No <input type="checkbox"/> |
| 2. Are your teeth sensitive to hot or cold liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 9. Do you clench or grind your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are your teeth sensitive to sweet or sour liquids/foods?..... | <input type="checkbox"/> | <input type="checkbox"/> | 10. Do you bite your lips or cheeks frequently?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you feel pain to any of your teeth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 11. Have you ever had any difficult extractions in the past?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have any sores or lumps in or near your mouth?..... | <input type="checkbox"/> | <input type="checkbox"/> | 12. Have you ever had any prolonged bleeding following extractions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you had any head, neck or jaw injuries?..... | <input type="checkbox"/> | <input type="checkbox"/> | 13. Have you had any orthodontic treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Have you ever experienced any of the following problems in your jaw? | | | 14. Do you wear dentures or partials?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Clicking..... | <input type="checkbox"/> | <input type="checkbox"/> | If yes, date of placement _____ | | |
| Pain (joint, ear, side of face)..... | <input type="checkbox"/> | <input type="checkbox"/> | 15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in opening or closing..... | <input type="checkbox"/> | <input type="checkbox"/> | 16. Do you like your smile?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| Difficulty in chewing..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X
Signature of patient (or parent/guardian if minor) _____

Doctor's Comments _____

Signature _____ Date _____

*Todd Ehrlich, DDS
11813 Bee Caves Road
Austin, TX 78738*

I authorize Smile Designs to release any information acquired in the course of my examination or treatment to my insurance company or other care providers that I have been referred to or from whom I choose to receive care. I authorize doctor to initiate a complaint to the insurance Commissioner for any reason on my behalf.

Acknowledgement of Receipt of HIPPA Privacy Practices Notice.

I acknowledge that I have received a Notice of Privacy Practices from the above named practice.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account. I have read all the information on this sheet and have verified the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you if any changes with my insurance or demographic information.

Patient Name (please print) _____

Signature **X** _____ Date _____

Parent or guardian _____ Date _____

Office Policy Regarding Dental Insurance

As a courtesy to our patients, we are happy to file your dental insurance claims for you at the time of your treatment. So that you fully understand how the process works, please read the following:

- You must bring a current **dental** insurance card. (Medical insurance cards are not the same).
- We will call to verify your coverage at the time of your appointment.
- After Dr. Ehrlich has seen you, you will then be asked to pay your deductible and/or percentage for that visit.
- We will file the claim for you (electronically, in most cases). If the x-rays or narratives are needed, we will send those with the claim through the mail.
- If, after 60 days, your account remains unpaid by your insurance, you will be responsible for the balance.
- Please keep in mind that **not all** services are covered by your insurance, and that it is the **patient's responsibility** to know their benefits.

Your dental insurance is a contract between your employer, and your carrier (we are a third party). Your employer purchases a fee schedule (UCR schedule) from an insurance company. Based on the plan "UCR schedule" your employer purchases is the amount your insurance will pay for your visit. For example, they will pay 100% of the fee schedule "UCR schedule" your employer purchased not our fee schedule. Our fee schedule is different from the fee schedule your employer purchased. Of course, the higher the plan your employer purchases, the more the insurance company pays. If you have any questions regarding the "UCR schedule" your employer purchased or specific benefit questions, please contact them directly. The 1800 number is typically located on the back of your dental insurance card. You may also contact your Human Resources department.

In cases of divorced parents, the parent bringing the child to the visit will be deemed responsible for payment. Our office will not become involved in custody disputes over which parent is the responsible billing party.

I have read the office policy stated above, and agree to accept responsibility as described. I authorize the release of my dental records or other information required to process all insurance claims.

Signature of Patient (or parent/guardian if minor)

Date