Portal Dental
PASADENA

3409 Spencer Hwy Suite.100 Pasadena, TX 77504
portaldentalpasadena@gmail.com
T 281.888.3454 **F** 281.888.4118

NEW PATIENT INFORMATION

How did you hear about us?_____

PATIENT'S Full Name: _____Phone/Mobile #:(_____)_____-_____

Patient's day of birth: _____/_____/_____ SSN#___/___/___/___/___/___/___/___/___/ Marital Status: ▢Single ▢Married ▢Minor

Sex ▢M ▢F Address:_____Apt.#_____City:_____

State:_____Zip:_____Email Address:_____

Emergency Contact Name:_____ Emergency Contact #:(_____)_____-_____

Reason for Today's Visit: _____ Date of Last Dental Visit: _____/_____/_____

IF PATIENT IS UNDER 18 **- PARENT or LEGAL GUARDIAN Full Name:**_____

PARENT or LEGAL GUARDIAN day of birth:_____/_____/_____ Relationship: _____

In general, the HIPAA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that the communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure made pursuant to an authorization request by the individual. Please initial acknowledging that you are aware of the HIPAA privacy rule above.INITIALS: _____

INSURANCE INFORMATION

Subscriber's Name: _____Subscriber's Birth Date: _____/_____/_____

Subscriber's SSN#_____/_____/_____/_____/_____/_____/_____/_____/_____/Relationship to Patient:_____

Employer Name:_____ Group #:_____

Insurance Name:_____Insurance Phone #: (_____)_____-_____

Member ID #:_____Insurance Fax #: (_____)_____-_____

DENTAL INSURANCE FINANCIAL POLICY: Our estimates regarding your dental insurance are given as carefully as possible. These estimates are given based on information provided and past history of your dental insurance company. However, your insurance company will decide on final approved treatment benefits. By signing our financial policy, the patient is responsible for any outstanding balances that the insurance has not reimbursed/unpaid claims and will be billed to the account on file. INITIALS: _____

DENTAL HISTORY

Name of Previous Dentist: _____

Have you had complications following dental treatment? ▢ Yes ▢ No If yes,please explain: _____

Would you change anything about the appearance of your teeth? ▢ Yes ▢ No If yes, please explain: _____

Have you had Orthodontic Braces? ▢ Yes ▢ No If yes, when? _____

Do you drink coffee/tea/soda? ▢ Yes ▢ No If yes, How Often? _____

Do you brush/floss? ▢ Yes ▢ No How Often? Brushing _____ Flossing _____

Do you have any of the following dental conditions?

Bad Breath ▢ Yes ▢ No	Periodontal Treatment ▢Yes ▢ No	Clicking or Popping Jaw ▢ Yes ▢ No
Bleeding Gums ▢ Yes ▢ No	Loose Teeth/ Broken Fillings ▢ Yes ▢ No	Sensitive to hot/cold/biting ▢ Yes ▢ No
Sores or Growths ▢ Yes ▢ No	Grinding Teeth ▢ Yes ▢ No	Food Catches Between Teeth ▢ Yes ▢ No

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MEDICAL HISTORY

Patient's Name:_____

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 dental care you will receive.

Are you under a physician's care now? ▢ Yes ▢ No If yes, please explain: _____

Have you ever been hospitalized or had a major surgery? ▢ 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 use tobacco or consume alcohol? ▢ Yes ▢ No If yes, how often: _____

WOMEN 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? PLEASE SPECIFIED IF ▢ Yes ▢ No If yes, please explain:_____

▢ Aspirin ▢ Penicillin ▢ Codeine ▢ Local Anesthetics ▢ Acrylic
▢ Metal ▢ Latex ▢ Sulfa Drugs ▢ Other If other, please explain:_____

Do you have, or have you had any of the following? ***VERY IMPORTANT - PLEASE MARK EACH ONE OF THE NEXT YES OR NO***

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

Have you ever had any serious illness not listed above? ▢ Yes ▢ No

Comments:_____

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.

_____ _____
NAME of PATIENT or PARENT or LEGAL GUARDIAN **RELATIONSHIP with PATIENT**

_____ _____/_____/_____
SIGNATURE of PATIENT or PARENT or LEGAL GUARDIAN **DATE**

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NO SHOWS / MISSED APPOINTMENT POLICY

When our office schedules your appointment, we are setting aside dedicated space and time slots just for you. We only ask that if you have to reschedule your appointment, for you to please provide us with at least 48 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who is patiently waiting for a sooner appointment.

There is a charge of $25 per visit for not showing up for scheduled appointments.

Repeat cancellations or missed appointments will result in loss of future appointment privileges.

Every patient in our practice receives a unique reservation. When your appointment is made, quality time is reserved, your materials are ordered, and we make special arrangements to be prepared for your visit.

Except for emergency treatment for another patient, you can expect us to be prompt.
We, of course, would appreciate the same courtesy from our patients.

By signing below, you acknowledge that you have read and understand our cancellation/missed appointment policy. We look forward to providing quality care to you and your loved ones!

_____ _____
NAME of PATIENT or PARENT or LEGAL GUARDIAN **RELATIONSHIP with PATIENT**

_____ _____/_____/_____
SIGNATURE of PATIENT or PARENT or LEGAL GUARDIAN **DATE**

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Patient's Name:_____**Patient's Day of Birth**:_____/_____/_____

Informed Consent for Dental Treatment

I understand that I or my child:_____ will have the following work done:
PATIENT'S NAME

▢**X-RAYS** ▢**EXAM** ▢**HOME CARE** ▢**OTHER:**_____**Initials**_____

PROPHYLAXIS:

During dental Prophylaxis (cleaning), I understand that it involves removing plaque and calculus above the gum line and will not include gum infections below the gum line called periodontal disease. I understand bleeding could last several hours. Should it persist, or is severe then you should receive attention immediately and this office must be contacted. It has been explained to me that there are certain potential risks of the procedure which include but are not limited to postoperative discomfort and swelling. Stretching the two corners of the mouth could result in cracking and bruising of the mouth. Swelling, bruising, and bleeding of the gum tissue. Shrinkage of the gum tissue. Sensitivity of the teeth. Loosening of the teeth. Fracture of fillings and porcelain of crowns. Exposure of margins of previous crowns or caps. **Initials**_____

_____ _____
NAME of PATIENT or PARENT or LEGAL GUARDIAN **RELATIONSHIP with PATIENT**

_____ _____/_____/_____
SIGNATURE of PATIENT or PARENT or LEGAL GUARDIAN **DATE**

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HIPAA Informed Consent Form

(Patients 18 years old and over must complete this form.)

-Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this consent by requesting a copy from the receptionist. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
-You have the right to request that we restrict how protected the health information about you is used or disclosed for treatment, payment or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.
-By signing this form, you consent to our use and disclosure of the protected health information about you for treatment, payment and health operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this notice.
The Practice reserves the right to change the Notice of Privacy Practices.
The patient has the right to restrict the use of their information, but the Practice does not have to agree to those restrictions.
The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition treatment upon execution of this Consent.

Below there is a list of ways the office could contact you. By checking any of the following options, you are giving us permission to send you full or partial information about your dental records when you need it. Please check all that apply:

Personal Email Address _____ **Cell Phone # (**_____**)**_____**-**_____
Work Email Address _____ **Work Phone # (**_____**)**_____**-**_____
Home Fax # (_____**)**_____**-**_____ **Work Fax # (**_____**)**_____**-**_____
Home Address _____
Work Address _____

List the names of who can have full or partial access to your medical information:

_____ Full access / Partial access _____

_____ Full access / Partial access _____

_____ Full access / Partial access _____

_____ _____
NAME of PATIENT or PARENT or LEGAL GUARDIAN **RELATIONSHIP with PATIENT**

_____ _____/_____/_____
SIGNATURE of PATIENT or PARENT or LEGAL GUARDIAN **DATE**

If patient or parent or legal guardian refuses to sign - Staff and one witness please sign below:

Staff Name and Signature_____**DATE** _____/_____/_____

Witness Name and Signature_____**DATE** _____/_____/_____

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Financial Policy

Thank you for choosing our office as your dental health care provider. Our primary responsibility is providing the highest quality dental care for you and your dependents, Part of our commitment is your understanding and responsibility for payment of your account balance,

Our basic financial policy Is the following:
FULL PAYMENT IS DUE AT THE TIME OF SERVICE, PAYMENT ARRANGEMENTS CAN BE MADE IF EXTENSIVE TREATMENT IS PLANNED AND APPROVED BY OUR OFFICE MANAGER. WE ACCEPT CASH, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS & CARE CREDIT. Adult Patients are responsible for full payment at the time of service unless specific arrangements are made prior to the start of treatment. We require at least half of the estimated patient portion for dentures, crowns, bridges and any other appliances on the procedure's start date. The remaining balance due is required upon the placement or delivery date. The Adult accompanying a Minor and the patients/guardians are responsible for full payment at the time of service. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized by credit card or by cash at the time of services has been verified.

REGARDING INSURANCE: We accept insurance. Full payment is required at the time of service, we will accept assignment of participating insurance plans and we will submit dental claims on our patient's behalf, and we will submit a refund for payment from an insurance company back to our patients in a timely fashion. We are not able to pre-determine or bill for insurance benefits only. A pre-treatment estimate will need to be submitted to your insurance company to determine the schedule of benefits for the services to be rendered. Your insurance policy is a contract between you and your insurance company: *we are not a party to that contract.* Any insurance claim not settled within 45 days will be due in full. It's your responsibility to pay our practice in full for the treatment invoice. Please be aware that some and perhaps all of the services provided may be non-covered services. You are responsible for the entire balance no matter what the outcome is with your insurance provider.

USUAL AND CUSTOMARY RATES Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for the quality of the treatment that is rendered. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. We will do all that is reasonable and proper to have received the maximum insurance benefits you are entitled to.

PATIENT RESPONSIBILITY AND ADDITIONAL TERMS Accounts unpaid after 60 days from day of service are subject to a delinquent fee of $35.00. Furthermore the unpaid balance is subject to a 1.5% monthly (18% Annual) finance charge. If we have to submit your unpaid account to a collections process you will be responsible for all charges our practice incurs; including collection fees, court costs and reasonable attorney's fee. Our entire staff is dedicated to YOU, the patient. Thank you for understanding and acceptance of our Financial Policy. Please let us know if you have any questions or concerns.

Initials: _____ **Patient Consent:** I have read the Financial Policy. I understand and agree to the terms of the Financial Policy of Portal Cypress Dentistry and Orthodontics. ***Picture ID is also required with your signature.***

_____ _____
NAME of PATIENT or PARENT or LEGAL GUARDIAN **RELATIONSHIP with PATIENT**

_____ _____/_____/_____
SIGNATURE of PATIENT or PARENT or LEGAL GUARDIAN **DATE**