DANIELLE E. AUSTIN, DMD

AUSTIN & TEAGUE
DENTAL

Patient Full Name: ______________________________ Preferred Name: _________________________

Parent or Guardian Name(s) (if patient is a minor – 18 & under): _______________________________________

Date of Birth: __________________________ Social Security Number: ________-_________-________

Mailing Address (Address, City, State, Zip): ____

Home Phone: ___________________ Cell Phone: _____________________ Work Phone: _____________

- Email Address: __________________ Best Phone # to Reach You: ☐Home ☐Cell ☐Work
- How may we remind you of upcoming appointment? ☐ Email ☐ Text ☐ Phone

Martial Status (Married/Divorced/Widow/Single) Employer: _________________________________

Who may we thank for referring you to our office? ____

Primary Dental Insurance Information (Leave blank if there is no Dental Insurance to file)

Insurance Company Name: ____

Name of Subscriber (Person who carries the insurance): ____

Subscriber's Social Security Number: _______-______-_______Subscriber's DOB:______________________

Subscriber's ID Number:_________________ Group Number: _____________________________________

Subscriber's Employer: ____

Secondary Dental Insurance Information (Leave blank if there is no Secondary Dental Insurance to file)

Insurance Company Name: ____

Name of Subscriber (Person who carries the Insurance): ____

Subscriber's Social Security Number: ______-______-___________ Subscriber's DOB: ________________

Subscriber's ID Number: _______________________ Group Number: _______________________________

Subscriber's Employer: ____

Broken Appointment and Cancellation Policy

We hold appointment times especially for you in good faith that you will be here. When patients do not show up or cancel at the last minute (regardless of the reason) we cannot fill the open slot. This results in nonproductive time which results in increased fees for everyone.

There will be a $25 or $50 charge for ALL missed appointments and cancellations with less than **24 business hours** prior to the scheduled appointment time.

We appreciate your understanding as we continue our efforts to provide you with quality dental care at a fair price.

Policy for Filing Insurance

Our office is NOT in any network; however as a courtesy we will file to all dental insurance companies. You will be responsible for any charges your insurance does not pay. If for any reason your insurance company has not paid within 60 days of treatment the balance will be your responsibility and you will need to refile with your insurance company. The patient's estimated portion will be due at the time of service.

By Signing Below, I attest that the above information is correct to the best of my knowledge. I also understand that payment is due when services are rendered and that I will be responsible for any amount that insurance does not cover.

Responsible Party Signature: ____Date: ____________

Health History

Are you currently being treated by a physician regularly for a serious health problem? Yes No

If yes, please explain and give physician's contact information: ___________________________________

____

____

Please list all medications you are currently taking (prescribed or over the counter): _________________

____

____

____

Do you have any known allergies to latex, medications, or milk protein (please list):

____

Have you ever been treated for: (circle all that apply)

Blood pressure	Heart Disease	Stroke	Artificial Joint
Rheumatic Fever	Heart Murmur	Heart Valve	Pacemaker
Hepatitis	Diabetes	Depression	Tuberculosis
Immune Disease	Asthma	Bleeding/Clotting	Dry Mouth

Has a physician told you to take antibiotics before a dental cleaning? ___________If yes, why?

____

Do you use tobacco? _____________ If yes, how much per day? _________________________________

Acknowledgement of Receipt of Notice of Privacy Practices

Austin & Teague Dental is committed to protecting your privacy. We will not release any information about you or your treatment without your consent. Only the people you list below will be authorized to receive your information:

Contact Person: ____________________________________ Relationship to You: ___________________

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I have been given a copy of Austin & Teague Dental's Notice of Privacy Practices to read. I have been offered a paper copy to take home.

Patient or Responsible Party: __________________________________Date: ________________