Welcome To Our Office! Thank you for choosing us as your dental care provider. We are dedicated to providing you the best dental care. If you have any questions while completing the form, we will be happy to assist you.

INFORMATION ABOUT YOU

Patient Name _____ Preferred Name _____ Social Security _____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Birth Date _____ Age _____ Driver's License #_____

Sex O Male O Female

Marital Status O Single O Married O Domestic Partner O Separated O Divorced O Widowed

Spouse's Name _____ Do you have children? Y / N If so, how many? _____

***RESPONSIBLE PARTY* (If someone other than the patient)**

Name_____ Relation_____ Social Security _____

Billing Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Birth Date _____ Age _____ Driver's License _____

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insured _____ Insured's Social Security _____

Insured's Date of Birth _____ Relation to Patient _____

Insurance Company _____ Phone _____

Address _____ City, State, Zip _____

Employer _____ Group Plan/Policy # _____

EMERGENCY CONTACT INFORMATION

Name _____ Address _____

Relation _____ Work Phone _____ Cell Phone _____

Primary Care Physician _____ His/Her Phone _____

Referred By: _____

DENTAL INFORMATION

Date of last dental visit _____ Last x-rays _____ Last cleaning _____

Reason for today's visit _____ Are you in pain? Y / N If so, for how long? _____

Do you use tobacco? Y / N How used? _____ How much? _____ How long? _____

Please indicate if you are experiencing any of the following:

O Lost/Broken filling(s) or teeth O Bad breath O Stained teeth O Loose teeth

O Red, swollen or bleeding gums O Teeth grinding or clenching O Discomfort, clicking or popping of the jaw

O Blisters/Sores in or around the mouth O Sensitive tooth or teeth O Sensitivity to hot/cold/sweets/pressure

O Dry mouth/mouth odor/bad taste O Other _____

Times a day you brush? _____ Times a day you floss? _____

What type of toothbrush bristle do you use? O Soft O Medium O Hard

How would you rate your smile? (1-least happy with it; 10-most happy with it) _____

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 ***Do you require pre-medication ?*** Y / N ***Why ?*** _____

Are you taking any of the following medications? O Nerve Pills O Pain killers O Aspirin O Muscle relaxers O Stimulants

O Blood thinners O Tranquilizers O Insulin O Other _____

Current Medications (Prescription, Over-The-Counter, Herbal)

MEDICATION	DOSAGE	FREQUENCY

Do you now have, or have you ever had, any of the following diseases or medical conditions?

Y N Alcohol/Drug Abuse
Y N Anemia
Y N Arthritis/Rheumatism
Y N Artificial Bones/Joints
Y N Artificial Valves
Y N Asthma
Y N Back Problems
Y N Bleeding Problems
Y N Cancer/Tumors
Y N Cerebral Palsy
Y N Chest Pains
Y N Chemotherapy
Y N Congenital Heart Defect
Y N Convulsions
Y N Depression (diagnosed)
Y N Diabetes/Hypoglycemia
Y N Dialysis
Y N Difficulty Breathing
Y N Eating Disorder
Y N Emphysema
Y N Fainting/Seizures/Epilepsy
Y N Fibromyalgia
Y N Frequent/Migraine Headaches
Y N Frequent Neck Pain
Y N Glaucoma
Y N Heart Attack/Stroke
Y N Heart Disease
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia
Y N Hepatitis A B C
Y N High/Low Blood Pressure
Y N High Cholesterol
Y N High Triglycerides
Y N HIV+/AIDS
Y N Immunological Disease
Y N Indwelling Defibrillator
Y N Jaw Problems/TMJ/TMD
Y N Kidney Problems
Y N Leukemia
Y N Liver Problems
Y N Lung Disease
Y N Lupus/Pemphilus
Y N Mitral Valve Prolapse
Y N Neurological Disease
Y N Organ Transplant
Y N Psychiatric Problems
Y N Radiation Treatment
Y N Respiratory Problems
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Shingles
Y N Sinus Problems
Y N Sleep Apnea
Y N Stomach Ulcers
Y N Thyroid Disease
Y N Tuberculosis/TB
Y N Venereal Disease

Other _____

Are you ***allergic*** to any of the following? O Latex O Penicillin/Amoxicillin O Tetracycline O Aspirin O Dental Anesthetics

Other _____

Are you currently under the care of a physician? Y / N If yes, please explain. _____

_____

Have you ever been hospitalized or had a major surgery? Y / N If yes, please explain. _____

_____

FOR WOMEN

Are you taking Birth Control Pills? Y / N What kind? _____

Are you pregnant? Y / N If so, how far along are you? _____ Are you nursing? Y / N

FOR EVERYONE

We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. For those with insurance, we file claims as a courtesy to our patients and we gladly accept assignment of benefit payments from most insurance companies. This will reduce your immediate, out of pocket expenditures. However, if your insurance company does not pay within 60 days of the date of service you will be billed for the remaining balance. Should your account continue to carry a balance after 30 days, with no financial arrangements having been made, you will be responsible for legal fees, collection agency fees, finance charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Up-dated Patient's Signature _____ Date _____

Up-dated Patient's Signature _____ Date _____

Up-dated Patient's Signature _____ Date _____

Up-dated Patient's Signature _____ Date _____

TROPHY DENTAL
Of PLANO

Patient Financial Responsibility

All co-pays and co-insurances required by your insurance company must be paid at the time services are rendered. We accept cash, Check, CareCredit, Visa, MasterCard, Amex and Discover. There is a *$35.00 charge* for returned checks. Fees are subject to change.

If you do not have insurance, payment in full is expected at the time of service unless financial arrangements have been made in advance. **As, an alternative, we accept CareCredit and can assist with application process.**

Dental Insurance and Your Financial Responsibility

You will receive a statement from our office within 45 days of your insurance company's response. If you are dissatisfied with their payment, please contact your insurance carrier. Payment of the patient's portion of the balance is due upon receipt of the statement.

If you will be utilizing dental insurance, we will be more than happy to file your claim as a ***courtesy*** to you, our patient. We do want to remind you of the following:

- ____You are financially responsible for any and all charges for services not paid by your insurance company for your dental visits.
- ____It is your responsibility and not the responsibility of the dentist to know if your insurance will pay for your dental services.
- ____It is your responsibility to know if your insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services you receive.
- ____It is your responsibility to know if the dentist you are seeing is a contracted, in-network provider recognized by your insurance company or plan.
- ____In the event a service is **"NOT COVERED"** by your insurance, you will be responsible for the complete charge.

As a ***courtesy*** to our patients, we try to give an ***ESTIMATE*** of what your insurance will pay for services from information we receive from your insurance representative, but in no way are we responsible nor ever guarantee payment from any insurance company.

Cancellation Policy

In order to ensure you, and the other patients, uninterrupted treatment, it is necessary for patients to adhere to all scheduled appointments. Once you have made an appointment, please remember that that time is reserved for you. As a courtesy to our patients, a friendly reminder call is made the 2 days **before** to confirm your appointment. Since our time and yours is so important, we ask that you make your very best effort to notify the office at the earliest possible time if an appointment change is necessary.
A *$ 50.00 charge* is made to your account if you DO NOT give at least a *48-hour notice*.

I hereby authorize the staff to take x-rays, study models, photographs, or other diagnostic aids deemed appropriate by the Doctor to perform any and all forms of treatment, medication, and therapy that may be indicated.

I have read, understand, and agree to the above policies.

_____
Print Name of Patient or Guardian

_____ _____
Signature of Patient or Guardian Date

1101 Jupiter Road
Plano, Texas 75074
(972) 422-5020 phone
(972) 578-6049 fax
trophydentalofplano@yahoo.com

TROPHY DENTAL
Of PLANO

Consent to Use and Disclosure of Protected Health Information for Purposes of Treatment, Payment, and Health Care Operations

Confirmation of Receipt: *Notice of Privacy Practices*

As a condition of providing treatment to you, our office must obtain your consent to use and disclose protected health information about you to carry out treatment, payment, and health care operations.

You may revoke this consent at any time by notifying us in writing, except to the extent that our office has taken action and reliance on your consent.

Your protected health information may be used and disclosed to carry out treatment, payment and/or health care operations.

Please refer to the Notice of Privacy Practices for Protected Health Information ("Privacy Notice") for a more complete description of the uses and disclosures that our office may use of your protected health information. You have the right to review the Privacy Notice prior to signing the consent.

In accordance with law, we have reserved the right to make any necessary changes to the terms of the Privacy Notice. At any time, you may obtain a copy of the current Privacy Notice and any revised notice by requesting the Privacy Notice in writing or by requesting a notice in person.

You have the right to request our office to restrict the manner in which your protected health information is used or disclosed to carry out treatment, payment and/or health care operations. We are not required, however, to agree to such requested restrictions. If, however, our office agrees to the requested restriction, we will honor the request and it will be binding on the office.

I hereby consent to the use and disclosure by Dr. N. Debbie Sudbrook, her Associate(s) and/or her staff of my protected health information for purposes of treatment, payment and/or health care operations. I also acknowledge receipt of a copy of the ***Notice of Privacy Practices.***

_____ _____

Signature of Patient or Guardian Date

1101 Jupiter Road
Plano, Texas 75074
(972) 422-5020 phone
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trophydentalofplano@yahoo.com

TROPHY DENTAL
Of PLANO

FINANCIAL RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for any and all charges for services not paid by my insurance company for my dental visits. This includes, but is not limited to, any dental service(s) or visit, preventative exam, x-ray(s), cleaning, filling(s), extraction(s), and any other service(s) provided by Dr. N. Debbie Sudbrook, her Associate(s) and/or her staff.

I understand and agree it is my responsibility and not the responsibility of the dentist to know if my insurance will pay for my dental service(s) or visit, preventative exam, x-ray(s), cleaning, filling(s), extraction(s), and any other service provided by Dr. N. Debbie Sudbrook, her Associate(s) and/or her staff.

I understand and agree it is my responsibility to know if my insurance has any deductible, co-payment, co-insurance, out-of-network amount, usual and customary limit, or any other type of benefit limitation for the services I receive, and I agree to make full payment.

I understand and agree it is my responsibility to know if the dentist or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the dentist or provider I am seeing is not recognized by my insurance company or plan, it may result in claims being denied or a higher out-of-pocket expense to me. I understand this and agree to be financially responsible and make full payment.

_____
Print Name of Patient or Guardian

_____ _____
Signature of Patient or Guardian Date

1101 Jupiter Road
Plano, Texas 75074
(972) 422-5020 phone
(972) 578-6049 fax
trophydentalofplano@yahoo.com

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____

(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____