

Welcome

Thank you for selecting us.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Patient Number _____
Name _____ Date _____
SS#/SIN _____ Birthdate _____ Home Phone _____
Address _____ City _____ State/Prov. _____ Zip/P.C. _____
Email _____ Cell Phone _____
Check Appropriate Box: Minor Single Married Separated Divorced Widowed
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 _____
Employer Address _____ 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 _____
Employer Address _____ 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 _____

- | | | | | | |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Are you under medical treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 10. Are you wearing contact lenses? | <input type="checkbox"/> | <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"/> | 11. Are you allergic to or have you had any reactions to the following? | | |
| If yes, please explain _____ | | | Local Anesthetics (e.g. Novocain) | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you taking any medication(s) including non-prescription medicine? | <input type="checkbox"/> | <input type="checkbox"/> | Penicillin or any other Antibiotics | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | Sulfa Drugs | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Have you ever taken Fen-Phen/Redux? | <input type="checkbox"/> | <input type="checkbox"/> | Barbiturates | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates? | <input type="checkbox"/> | <input type="checkbox"/> | Sedatives | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours? | <input type="checkbox"/> | <input type="checkbox"/> | Iodine | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you use tobacco? | <input type="checkbox"/> | <input type="checkbox"/> | Aspirin | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> | Any Metals (e.g. nickel, mercury, etc.) | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have or have you had the following? | | | Latex Rubber | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Other _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | 12. 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"/> |
| | | | 13. Women Only: | | |
| | | | Are you pregnant or think you may be pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you nursing? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | Are you taking oral contraceptives? | <input type="checkbox"/> | <input type="checkbox"/> |

- | | | | | | | | | |
|-----------------------|--------------------------|--------------------------|------------------------------|--------------------------|--------------------------|-----------------------|--------------------------|--------------------------|
| High Blood Pressure | Yes | No | Heart Disease | Yes | No | Chest Pains | Yes | No |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> | Cardiac Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Easily Winded | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic Fever | <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Stroke | <input type="checkbox"/> | <input type="checkbox"/> |
| Swollen Ankles | <input type="checkbox"/> | <input type="checkbox"/> | Angina | <input type="checkbox"/> | <input type="checkbox"/> | Hay Fever/Allergies | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting/Seizures | <input type="checkbox"/> | <input type="checkbox"/> | Frequently Tired | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Radiation Therapy | <input type="checkbox"/> | <input type="checkbox"/> |
| Low Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Epilepsy/Convulsions | <input type="checkbox"/> | <input type="checkbox"/> | Cancer | <input type="checkbox"/> | <input type="checkbox"/> | Recent Weight Loss | <input type="checkbox"/> | <input type="checkbox"/> |
| Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Arthritis | <input type="checkbox"/> | <input type="checkbox"/> | Liver Disease | <input type="checkbox"/> | <input type="checkbox"/> |
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Joint Replacement or Implant | <input type="checkbox"/> | <input type="checkbox"/> | Heart Trouble | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney Diseases | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis/Jaundice | <input type="checkbox"/> | <input type="checkbox"/> | Respiratory Problems | <input type="checkbox"/> | <input type="checkbox"/> |
| AIDS or HIV Infection | <input type="checkbox"/> | <input type="checkbox"/> | Sexually Transmitted Disease | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid Problem | <input type="checkbox"/> | <input type="checkbox"/> | Stomach Troubles/Ulcers | <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 _____

- | | | | | | |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Do your gums bleed while brushing or flossing? | <input type="checkbox"/> | <input type="checkbox"/> | 8. Do you have frequent headaches? | <input type="checkbox"/> | <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 _____ _____ _____	Date _____
Signature _____	Date _____

Christopher S. Moore, DDS
1020 Bay Area Blvd., Suite 238
Houston, Texas 77058

281-488-6862 (Ofc)
281-488-8434 (Fax)

Financial Policy

This is an agreement between Christopher S. Moore, DDS as creditor, and the Patient/Debtor named on this form. In this agreement the words "you," "your," and "yours" means the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Christopher S. Moore, DDS.

By signing this agreement, you are agreeing to pay in full for all services that are received.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show any new charges to the account, the finance charge (if any) and any payments or credits applied to your account during the month. It will reflect any balances still owed on the account whether by the patient or by the insurance company. Unless we approve other arrangements in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within 15 days.

If you have insurance:

- You must pay your deductible, any non-covered services and co-payments required by your insurance company at the time services are rendered.
- We allow 45 days from the date a claim is filed by our office for the insurance company to pay. **If the insurance company has not paid within this time, you are responsible for the entire balance, without further notice.** We cannot become involved in disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. **You are responsible for timely payment of your account.**

If you have no insurance:

- Payment is required when services are rendered. We accept checks, credit and debit cards, and cash.
- If your total treatment plan exceeds \$2500 you may choose to **prepay** the entire plan by cash, check or credit card on the day treatment is rendered and receive a 5% discount.
- With extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution. Ask our staff about your options.

I request payment of authorized Insurance Company benefits to be made on my behalf to Christopher S. Moore, DDS, for any services furnished to me by that party who accepts assignment (Dentist). I authorize any holder of dental or other information about me to release any information needed for this or a related Insurance Company claim. I permit a copy of this authorization to be used in place of the original.

I understand it is mandatory to notify the health care provider of any other party who might be responsible for paying any treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) I hereby attest that I do not have additional health/dental care coverage other than the insurance supplied by myself or legal guardian at the time of my appointment.

Insurance: Your dental insurance is a contract between you and your insurance company. We have no control over this contract. We will bill your primary insurance as a courtesy to you. Although we will make a good-faith estimate as to the amount your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and claim reimbursement. You agree to pay any portion of the charges not covered by insurance. If the insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower payment from your insurance company. **Please become familiar with the details of your insurance plan.**

The financial policy continues on the other side of this page.

Initials _____

Financial Policy (continued from previous side)

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit-reporting agency such as a credit bureau.

Finance charge: A finance charge may be imposed on each item of your account which has not been paid within thirty (30) days of the time the item was added to the account. The finance charge will be computed at the rate of one and one-half percent (1.5%) per month or an ANNUAL PERCENTAGE RATE of eighteen (18%) percent. The finance charge on your account is computed by applying the periodic rate (1%) to the overdue balance of your account. The overdue balance of your account is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The minimum Finance Charge is \$1.00.

Returned Checks: The fee for any checks returned by the bank is \$30.00.

Missed Appointment Fee: Patients who do not show up for any appointment, or **cancel with less than 24 hours notice** will be charged a \$30.00 fee. This fee must be paid before a new appointment is scheduled. Patients with three missed appointments may be asked to transfer their records to another doctor.

Past Due Accounts: If your account becomes past due, we may take necessary steps to collect this debt. If we have to refer your account to the Credit Bureau and/or collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all legal fees which we incur plus court costs. In case of suit, you agree the venue shall be in Harris County, Texas.

Waiver of Confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Minors: The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. An unaccompanied minor must have authorization for dental treatment signed by a parent or guardian and is responsible for providing current insurance information and/or payment in full for services provided.

In case of a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee (currently \$25.00) if you want to have copies of your records sent to another doctor or organization. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Co-signature: If another person signs this or another Financial Policy, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's Name: _____ Guarantor's Name: _____

Signature: _____ Date: _____

Co-signature: _____ Date: _____

FAMILY AND FRIENDS CONTACT FORM

Persons who are involved in your care (family, friends, other doctors, etc.) may inquire about your treatment, lab results, prescriptions, etc. Please let us know what persons we may share information with. (Please note: In emergency situations or other situations outlined in our Notice of Privacy Practice we may share information with others who are not specifically listed on this form.)

Please list those persons (including Family, Friends, Previous Treating Physicians, your Family Doctor (PCP), and other doctors/specialists) with whom we may share your information:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What is the best phone number for us to contact you?

Phone Number: _____

What is this number (Home, Work, Cell, Other)? _____

From time to time we will leave a message for you (as stated in our Notice of Privacy Practices) on an answering machine, voice mail, or with another individual in your absence. **Is it OK for such message to include details (such as diagnosis and medication information) at this number?** _____

What other ways may we contact you? Please list any that are acceptable ways to reach you.

Home Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Work Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Cell Phone Number: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Other: _____

Is it OK to leave a **detailed** message at this number in your absence? _____

Email: _____

We may send appointment reminders, treatment plans, and other information you request to this address.

Signature of Patient or Legal Representative

Date

Print name of Patient or Legal Representative

Relationship to Patient

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Christopher S. Moore, DDS

I, [name of patient] _____, acknowledge and agree that I have reviewed a copy of the **Christopher S. Moore, DDS Notice of Privacy Practices**.

Patient Signature

Date

Signature of Patient's Legal Representative (if applicable)

Date

Print Name of Legal Representative

Relationship to patient

Clinic Use Only:

Christopher S. Moore, DDS made the following good faith efforts to obtain the above-referenced individual's written acknowledgement of the Notice of Privacy Practices: **[Identify the efforts that were made to obtain the individual's written acknowledgement, including the reasons (if known) why the written acknowledgement was not obtained.]**

Signature of Employee

Date

Print Name of Employee

Title