Ashly Cothern, D.D.S.

9669 N. Central Expressway • Suite 220 • Dallas, Texas 75231
214-696-9966

PATIENT INFORMATION

Name(First, Middle initial, Last) _____ Preferred Name_____
Address_____ Phone #_____
City, State, Zip _____Social Security # _____
M_____F_____Age_____Birthdate_____Married_____Divorced_____Widowed_____Single_____
Employed by_____Phone#_____
Address_____ Occupation _____
City, State, Zip _____ E-mail _____
Would you like to receive text message reminders? Y N Would you like to receive email reminders? Y N

SPOUSE OR RESPONSIBLE PARTY

Name(First, Middle initial, Last)_____ Relationship to patient_____
Address_____ Phone #_____
City, State, Zip_____ Social Security # _____
Employed by_____ Phone #_____
Address_____
City, State, Zip_____
Please list all family members cared for in our office _____

DENTAL INSURANCE

Company name _____
Phone #_____Group ID #_____
Secondary coverage_____
Phone #_____Group ID #_____

DENTAL / MEDICAL HISTORY

In case of an emergency, notify_____Phone #_____
Physician_____Last physical_____Phone #_____
Pharmacy_____ Phone #_____
Please list all medications presently taking_____
Do you have allergies or adverse reactions to any medication?_____Yes_____No If so, please list all medications: _____
_____
Last dental visit_____Have you had any previous dental treatment problems?_____

Do you have or have you had any of the following: please answer by putting an X by each question.

Heart Failure	Y	N	Glaucoma	Y	N	Pain in Jaw Joint	Y	N
Heart Disease	Y	N	Anemia	Y	N	Epilepsy, Seizures	Y	N
Heart Murmur	Y	N	Bleeding Problems	Y	N	Emphysema	Y	N
Congenital Heart Lesions	Y	N	Hemophilia	Y	N	Tuberculosis(TB)	Y	N
Angina Pectoris	Y	N	Kidney Trouble	Y	N	Asthma	Y	N
Artificial Heart Valve	Y	N	Hepatitis A(infectious)	Y	N	Sinus Trouble/ Allergies	Y	N
Heart Pacemaker	Y	N	Hepatitis B(serum)	Y	N	Diabetes	Y	N
Heart Surgery	Y	N	Liver Disease	Y	N	HIV Positive	Y	N
High Blood Pressure	Y	N	Jaundice	Y	N	AIDS	Y	N
Rheumatic Fever	Y	N	Ulcers	Y	N	Venereal Disease	Y	N
Stroke	Y	N	Tumors/Growths	Y	N	Cold Sores, Fever Blisters	Y	N
Neurological Problems	Y	N	X-ray treatments	Y	N	Do you use tobacco	Y	N
Psychological Problems	Y	N	Cancer or Chemotherapy	Y	N	Do you drink alcohol	Y	N
Cortisone or Steroids	Y	N	Artificial Joints	Y	N	Are you pregnant	Y	N
Thyroid Disease	Y	N						

I hereby grant permission for dental treatment to be performed and will assume all responsibilities connected with such treatment. A broken appointment is a loss to everyone. ***Please inform us 48 hours in advance if you are unable to keep your appointment. If you fail to do so, there will be a minimum charge of 100.00.***

Patient's (or Legal Guardian's) Signature_____Date_____

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EXAMINATION QUESTIONAIRE

In order for us to give you an accurate diagnosis and the best treatment possible, please take a few minutes to answer the following questions thoroughly. Thank you.

Name _____ Date _____

How long has it been since you've had any of the following?

Dental exam _____ Dental x-rays _____ Professional cleaning _____

What prompted you to seek dental care at this time? _____

Are you satisfied with your past dental experiences? _____

Have you had your wisdom teeth removed? _____ Have you worn braces in the past? _____

Do you wear an appliance (retainer/night guard/snore guard/CPAP)? _____

How often do you usually perform any of the following?

Brush _____ Floss _____ Professional cleaning _____

Please circle any of the following that pertain to you:

Bleeding gums	Crooked teeth	Hot/Cold Sensitivity	Snoring
Chewing sensitivity	Discoloration	Joint discomfort	Tender gums
Clenching/Grinding	Fatigue	Poor sleep	Throbbing pain
Congestion	Frequent headaches	Seasonal allergies	

If you circled any of the above items, please explain. _____

_____

Is there anything you would like to change about the appearance of your smile? _____
If so, please explain. _____

Please circle any of the following areas of interest:

Whitening	Invisalign	Crowns	Snore Guard
Bonding	Cosmetic Dentistry	Veneers	Night Guard

On a scale of 1-10, 10 being very important, how important are your teeth? _____
Whom may we thank for your referral? _____

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FINANCIAL/ INSURANCE INFORMATION

Full name of policy holder:_____
Social Security # of policy holder:_____
Date of birth of policy holder: _____

Dental insurance company name and mailing address:

_____
_____
_____

Phone#:_____ **Group ID#:** _____

We will do our best to estimate what each insurance company will cover. Keep in mind we are not a preferred provider on any plan. Please note it is only an estimate and the patient will be responsible for the entire remaining balance for themselves and/or their dependent(s) at time of treatment.

We have several payment options:

- If treatment is paid in full with cash or check a **5% courtesy** will be extended. Any insurance reimbursements will be paid directly to the patient. (Applies only to treatment over $1000).
- Payments may be made in full by Visa, Master Card, and American Express.
- Flexible monthly payments available with **Care Credit**.
- **3 equal payments** with post dated check or with credit card number (1/3 down at start of treatment) for treatment over $1000.
- **If insurance payments are not received 30 days after treatment the patient will be asked to pay in full.**
- As a courtesy, **we will file your insurance** after an estimated patient portion is paid however, to file your insurance we must have a credit card on file.

I hereby grant permission for dental treatment to be performed and will assume all responsibilities connected with such treatment.

Patient's (or Legal Guardian's) Signature _____

Witness_____Date:_____

ASHLY COTHERN DDS

Pre-Authorized Health Care Form

I authorize **Ashly Cothern DDS** to keep my signature on file and to charge my credit/debit account for the balance of charges not paid by insurance within 60 days.

I understand that this form is valid unless I cancel the authorization through written notice to the health provider.

Patient Name: _____

Cardholder Name: _____

Cardholder Address: _____

City: _____

State: _____Zip: _____

Cell Phone #: _____

Card of Choice: MC_____ Visa_____ Amex _____ Discover _____ HCFP_____

Account Number: _____

Expiration Date: _____

Security Code: _____

Cardholder Signature: _____

Date: _____

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Due to the **Health Insurance Portability and Accountability Act**, our privacy policy is now available to our patients. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office waiting room for patient's review. Your signature is your acknowledgement of this HIPAA policy.

Patient signature _____ **Date:** _____

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a right to read our *Notice of Privacy Practices* before you decide whether to sign this consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

I, _____, have had the opportunity to read and consider the contents of this consent form and Dr. Ashly Cothern's *Notice of Privacy Practices*. I understand that by signing this form, I am giving my consent to Dr. Ashly Cothern's use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient signature _____ **Date:** _____

Thank you for your cooperation in complying with the Federal HIPAA Regulations. This privacy of your health information is important to us. At your request, we will by happy to provide you with a copy of this consent form.