7 Day Dental

Patient Information

Patient: ____
First Name Middle Last Name
Address: _________________________________ Apt ________
City: ________________________ State: ______ Zip: __________
Date of Birth: ___________________ Age: ________
Sex: ___M ___F Social Security: ______-_______-________
Home Phone: ___________________ Cell: _________________
Work: ______________________
Marital Status (check one): ___Married ___ Single ___Minor
___Divorced __Widowed

May we send you correspondence via email? Y / N
Email: ____
May we send you appointment reminders via text to your cell number? Y / N
Person authorized to receive patient records' information:
Full Name:____
Relationship:______________ Phone: ____________________
Emergency Contact: ____________________________
Relationship:______________ Phone: ____________________

Insurance Information

Policy Holder: ______________________________________
First Name Middle Last Name
Relationship to patient: _________________________
Birth Date: ______________ Age:_______
Soc. Sec. Number: ________-_________-_________
Employer: ______________________________________
Insurance Company Name: _________________________
Subscriber ID: ___________________Group #: __________

Responsible Party

Full Name:______________________________________
Date of Birth: _________ Phone #: _________________
Relationship: ____________________

Referral Source

How did you hear about us? _________________
Whom may we thank for referring you?
Name: ____________________________
◊Family ◊Friend ◊Co-Worker
◊Other:_________________

Medical History

Are you under a physician's care now? Y / N if yes, please explain: ____
Have you ever been Hospitalized or had a major operation? Y / N if yes, please explain: ____________________________
Have you ever had a serious head or neck injury? Y / N if yes, please explain: ____________________________________
Are you taking any medications, pills, or drugs? Y / N if yes, please explain:_______________________________________
____
Do you take, or have taken Fosamax, Boniva, Acetonel, or any other medications containing biosphonates? Y / N if yes, please explain:____
Are you on a special diet? Y / N if yes, please explain: ____
Do you use tobacco? Y / N

Women Only: Are you- Pregnant/Trying to Get Pregnant? Y / N Taking Oral Contraceptives? Y / N Nursing? Y / N

Are you ***allergic*** to any of the following (check all that apply):
___Aspirin ___Penicillin ___Codeine ___Local Anesthetics ___Acrylic ___Metal ___Latex ___Sulfa Drugs ___Other:__________

Please fill in circle of the following medical conditions of which you have had, or presently have:

- ○ AIDS/HIV Positive
- ○ Alzhimer's Disease
- ○ Anaphylaxis
- ○ Anemia
- ○ Angina
- ○ Arthritis/Gout
- ○ Artificial Heart Valve
- ○ Artificial Joint
- ○ Asthma
- ○ Blood Disease
- ○ Blood Transfusion
- ○ Breathing Problem
- ○ Bruise Easily
- ○ Cancer
- ○ Chemotherapy
- ○ Chest Pains
- ○ Cold Sores/Fever Blisters
- ○ Congenital Heart Disorder
- ○ Convulsions
- ○ Cortisone Medicine
- ○ Diabetes
- ○ Drug Addiction
- ○ Easily Winded
- ○ Emphysema
- ○ Epilepsy or Seizures
- ○ Excessive Bleeding
- ○ Excessive Thirst
- ○ Fainting Spells/Dizziness
- ○ Frequent Cough
- ○ Frequent Diarrhea
- ○ Frequent Headaches
- ○ Genital Herpes
- ○ Glaucoma
- ○ Hay Fever
- ○ Heart Attack/Failure
- ○ Heart Murmur
- ○ Heart Pacemaker
- ○ Heart Trouble/Disease
- ○ Hemophilia
- ○ Hepatitis A
- ○ Hepatitis B or C
- ○ Herpes
- ○ High Blood Pressure
- ○ High Cholesterol
- ○ Hives or Rash
- ○ Hypoglycemia
- ○ Irregular Heartbeat
- ○ Kidney Problems
- ○ Leukemia
- ○ Liver Disease
- ○ Low Blood Pressure
- ○ Lung Disease
- ○ Mitral Valve Prolapse
- ○ Osteoporosis
- ○ Pain in jaw joints
- ○ Parathyroid Disease
- ○ Psychiatric Care
- ○ Radiation Treatments
- ○ Recent Weight Loss
- ○ Renal Dialysis
- ○ Rheumatic Fever
- ○ Rheumatism
- ○ Scarlet Fever
- ○ Shingles
- ○ Sickle Cell Disease
- ○ Sinus Trouble
- ○ Spina Bifida
- ○ Stomach/Intestinal Disease
- ○ Stroke
- ○ Swelling of Limbs
- ○ Thyroid Disease
- ○ Tonsillitis
- ○ Tuberculosis
- ○ Tumors or Growths
- ○ Ulcers
- ○ Venereal Disease
- ○ Yellow Jaundice

Comments: ____

Patient, Parent, or Guardian Signature: __________________________________ Date: __________________

FINANCIAL POLICY

We ask that all patients read and sign our financial policy as well complete our patient information form prior to seeing the dentist. Payments of services are due at the time services are rendered. We accept cash, credit, check and care credit. We may accept assignments of insurance benefits. However you must understand that:

*Your insurance policy is a contract between you, your employer and the insurance company. We are not a party of that contract! Our relationship is with you, not your insurance company. Our involvement will be limited to supplying factual information to facilitate claim processing.

***All charges are your responsibility whether your insurance company pays or does not pay.** Not all services are covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

*Fees for services, along with unpaid deductibles and co-payments are due at the time of treatment.

*I understand that the employees of 7 DAY DENTAL and associates are not representatives for my insurance company and the estimate I receive from them is not a guarantee of payment from my insurance company. Estimates are only good for 30 days. If your insurance does not pay within 30 days, it's your responsibility to contact your insurance to expedite payment. **IF YOUR INSURANCE DOES NOT PAY, YOU ARE RESPONSIBLE FOR YOUR PAYMENT.** If for some reason your account incurred an unpaid balance older than 30 days, it may be subject to collection placement and fees.

*I authorize this office to release necessary dental information about any dependants or myself to my insurance carrier.

*I authorize my insurance to send payments directly to the provider.

FIXED OR REMOVABLE PROSTHETICS: All dentures, crowns, or bridges, are understood to be a product that is uniquely suited to each particular patient. The full amount contracted for such services is, therefore, considered to be due and payable when the initial impression is made. We accept insurance payment for the covered portion; however you must pay your portion at the time services are rendered. Prosthetics must be seated in a timely manner to insure your comfort and proper fit. If you failed to have a prosthetic permanently seated within **60 days** from the date of the impression, or a second impression must be made, you will be charged a **$150.00 fee plus any lab fees**. There will be no reimbursement on fixed or removable prosthetics.

ALL X-RAYS TAKEN ARE PART OF OUR PERMANENT RECORDS. THERE IS A $15.00 DUPLICATION CHARGE FOR ANY X-RAYS REMOVED FROM THIS OFFICE (ADDITIONAL DUPLICATION IS $10.00).

Thank you for choosing 7 Day Dental and associates as your dental providers. We appreciate your trust and the opportunity to serve you.

OUR NOTICE OF PRIVACY PRACTICES

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information that we already have as to such information that we may generate in the future. If we change our Notice of Privacy Practices, we will post the new notice in our office, have copies available in our office, and post it on our Website.

Our goal is to provide quality dental care in a timely manner. In order to do so we have had to implement a cancellation and no show policy. The policy enables us to better utilize available appointment for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT: In order to be respectful of other patients' needs, please be courteous and call our office promptly if you are unable to attend an appointment. This time will be given to someone who is in urgent need of treatment. We ask that you make an attempt to call **24 hours** in advance.

NO SHOW POLICY: A "no show" is an appointment that was not cancelled in advance. No shows inconvenience other patients who need dental care. A no show for a scheduled appointment will result in a fee of **$25** for every half hour scheduled.

COMPLAINTS

If you think that we have not properly respected the privacy of your health information, you are free to complaint to us or the U.S Department of Human Services, Office of Civil Rights.

Region VI- Dallas (Arkansas, Louisiana, New Mexico, Oklahoma, Texas)

Ralph Rouse, Regional Manager
Office for Civil Rights
U.S Department of Health and Human Services
1301 Young Street, Suite 1169, Dallas, TX 75202
Voice Phone (214)767-4056, FAX (214)767-0432, TYDD (214)767-8940

We will not retaliate against you if you make a complaint. If you want to complaint to us, send a written complain to the office contact person at the address of 115 W.Seminary Dr. #101 Fort Worth Tx 76115 FAX (817)529-1795 or via e-mail at 7daydental@gmail.com. If you prefer, you can discuss your complaint in person or phone.

FOR MORE INFORMATION

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number listed above in this notice.

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Dr. Jing's Notice of Privacy Practices.

PATIENT SIGNATURE: ______________________________ **DATE:** ____________________