Dr. Fred Haight, DDS Dr.
Taylor Niggle, DDS Dr.
Katie James, DDS

Compassion • Integrity • Convenience

www.HaightFamilyDentistry.com

6317 Preston Road Suite 500
Plano, TX 75024
Tel: 972-527-5555

1711 Cooper Street
Melissa, Texas 75454
Tel: 972-838-4500

PATIENT INFORMATION

Date: ______________ ☐New Patient ☐Update

Patient: ______________________________

Last | First | MI | Preferred | Title

☐Male ☐Female ☐Child* ☐Student** ☐Single ☐Married ☐Divorced ☐Widowed

*If Child, provide parent/guardian name(s) below:

____
Parent/Guardian Name(s)

**If Student, please complete: ☐Full-time ☐Part-Time

____
School/Location

Patient Date of Birth: ______________ Patient SSN: ______________

Address: ______________________________
Address Line 1

____
Address Line 2

____
City | ST | Zip Code

Home: ______________
Cell: ______________
Other: ______________
Pager: ______________
Fax: ______________

E-Mail: ______________________________

Referral? ☐Yes ☐ No Referred by: ______________________________

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

______________________________ Tel: ______________
Name | Relationship

INSURANCE INFORMATION

Subscriber: ______________________________

Last | First | MI | Preferred | Title

Subscriber Date of Birth: ______________ Subscriber SSN: ______________

Subscriber Employer: ______________________________

Patient Relationship to Subscriber: ☐Self ☐Spouse ☐Child ☐Other

Primary Insurance Carrier: ______________________________

Group/Policy No.: ______________ ID#.: ______________

Address: ______________________________ Tel: ______________

______________________________ Toll-free: ______________

Fax: ______________

____
City | ST | Zip Code

Secondary Insurance Carrier: ______________________________

Group/Policy No.: ______________ ID No.: ______________

Address: ______________________________ Tel: ______________

______________________________ Toll-free: ______________

Fax: ______________

____
City | ST | Zip Code

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DENTAL HISTORY

ORAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

Date of Last Dental Visit: ____________________ Treatment Type: ____________________

Would you like to have a VisiLite oral cancer screening? ☐Y☐N

**Note: Some insurance plans do not cover this service; please check your plan documents for details.*

☐Y☐N Are you currently having dental discomfort? If yes, explain: ____________________
☐Y☐N Any unhappy/unpleasant dental experiences? If yes, explain: ____________________
☐Y☐N Any injuries to mouth/teeth/head? If yes, explain: ____________________
☐Y☐N Any missing teeth other than wisdom teeth or orthodontic extractions?
☐Y☐N Have missing teeth been replaced?
☐Y☐N Orthodontic appliances now or in the past?
☐Y☐N Gums bleed when brushing or flossing?
☐Y☐N Concerned about gum disease? History of gum disease? ☐Y☐N
☐Y☐N Any concerns about the appearance of your teeth?
☐Y☐N Does it hurt to bite or chew?
☐Y☐N Do you clench or grind your teeth? If so, do you wear a night guard or splint? ☐Y☐N
☐Y☐N Do you want to become a regular continuing care patient in our practice?
☐Y☐N Do you want your mouth properly restored and pain free?
☐Y☐N Does any type of dental treatment make you nervous? If yes, please explain below:

____

The most important concerns regarding my dental treatment are:

____

What factors are most important for your satisfaction with our office?

____

Any additional concerns/comments?

____

Please Read prior to filling out Medical History:

Although dental personnel primarily treat 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 thoroughly answering the following questions.

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PRIMARY PHYSICIAN INFORMATION

Physician: ______________________ **Telephone:** ______________________

Clinic:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR

- ☐Y☐N Under a physician's care now?
- ☐Y☐N Any hospitalization in the past 5 years? ______________________
- ☐Y☐N Any serious illnesses/surgeries? ______________________
- ☐Y☐N Use tobacco in any form? If Yes, Type: ______________________
- ☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
- ☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: ____________

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

____

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANGINA	☐BLOOD TRANSFUSION	☐EMPHYSEMA	☐PSYCHIATRIC TREATMENT
☐ALZHEIMER'S DISEASE	☐CANCER	☐EXCESSIVE BLEEDING	☐RADIATION
☐AIDS/HIV CIRCLE	☐CHEMO THERAPY	☐GLAUCOMA	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEST PAINS	☐HEART MURMUR	☐RHEUMATIC FEVER
☐ANAPHYLAXIS	☐COLD SORES	☐HEPATITIS A, B OR C (CIRCLE)	☐SINUS PROBLEMS
☐ANXIETY	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐CONGENITAL HEART DISORDER	☐HEART ATTACK/DISEASE	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐CORTISONE MEDICATION	☐KIDNEY/ LIVER DISEASE	☐TUBERCULOSIS
☐ARTHRITIS	☐DIABETES	☐HEART PACEMAKER	☐ULCERS
☐ASTHMA	☐DIZZINESS/ FAINTING	☐EXCESSIVE THIRST	☐VENEREAL DISEASE/ STD
☐BREATHING PROBLEMS	☐EPILEPSY/ SEIZURES	☐ MITRAL VALVE PROLAPSE	
☐BLOOD DISORDER	☐FREQUENT HEADACHES	☐HIGH CHOLESTEROL	OTHER: ____________

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/OTHER ANTIBIOTICS

☐OTHER – PLEASE LIST: ______________________

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS

☐OTHER (PLEASE LIST BELOW)

DRUG NAME	DOSAGE	REASON PRESCRIBED

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Financial Guidelines/Office Policies

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines. We ask that you provide us with any changes to your insurance no later than 48hours prior to your appointment.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.
- **Workers Compensation claims** will be filed for you. Please understand the carrier will assign a dollar amount that will be paid towards the claim, which *may or may not* cover the entire fee. Any amount not covered by the carrier, will be your responsibility.
- **Minors must be accompanied by a parent or legal guardian**. If the parents are separated or divorced, the person accompanying the minor will be responsible for co-payment at the time of service.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
  - All major credit cards are accepted (Visa, MasterCard, Discover, American Express)
  - 10% Discount for Senior Citizens
  - 5% Cash Disounct when paid in full
  - Various financing options with CareCredit®
- **Balances left over 90 days will began going through the process of collections:** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you *to contact us promptly* for assistance in the management of your account.

Short Cancelled/ Missed Appointments

When your appointment is made, a room is reserved, your records are prepared and special instruments are readied for your visit. Except for emergency treatment for another patient, you can expect us to be prompt. We ask that if you must change an appointment, you give at least 24 hours notice. This makes it possible to give your reserved room to another patient.
There is a $25 charge for not showing up to your appointment.
Repeated cancellations or missed appointment will result in loss of future appointment privileges.

By signing below, I acknowledge I have read and understand the guidelines above.

Signature: ______________________________ **Date:** ____________________

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: PATIENT GIVING CONSENT

Patient's Name: ____

Address: ____

Telephone Number: ____________________________________ Email Address: ____________________________________

Section B: TO THE PATIENT – PLEASE READ THE FOLLOW STATEMENTS CAREFULLY

Purpose of Consent: 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.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Please ask for a copy if you chose to do so. Our Notice provides a description of our treatment, payment activities, and healthcare operations of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it completely before signing this document.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of you protected health information that we obtain.

You may obtain a copy of Notice of Private Practices, including any revisions, at any time by contacting:
Telephone: 972-527-5555 **Fax:** 972-378-0810 **Email:** frontdesk@drhaight.com
Address: 6317 PRESTON RD. STE. 500, PLANO, TX 75024

I, ______________________ have had full opportunity to read and consider the contents of this Consent form and Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my/my child's protected health information to carry out treatment, payment activities and healthcare operations.

Signature: ____ **Date**: ____

If this Consent is signed by a guardian or personal representative on behalf of the patient, please complete the following:

Guardian/ Personal Representative Name: ____

Relationship to Patient: ____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

REVOCATION OF CONSENT:
I revoke my Consent for you and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of Consent will not affect any action you took in reliance on this Consent before you received my revocation, and that you may decline to treat me or to continue treating me if I have revoked this consent.

Signature: ____ **Date:** ____