Fischer DENTAL
COSMETIC | IMPLANT | RESTORATIVE

PATIENT INFORMATION			
□ Mr. □ Ms. □ Mrs. □ Dr.	LAST NAME	FIRST NAME	MI
PREFERS TO BE CALLED		□ MALE □ FEMALE	
BIRTH DATE		SOCIAL SECURITY NUMBER (IN ORDER TO FILE CLAIMS IF INSURED)	
PLEASE CIRCLE ONE: SINGLE MARRIED PARTNERED DIVORCED WIDOWED			
ADDRESS	CITY	STATE	ZIP
HOME PHONE NUMBER	CELL PHONE NUMBER	MAY WE TEXT APPOINTMENT INFO? □ Yes □ No	
EMAIL ADDRESS	WOULD YOU LIKE TO RECEIVE EMAIL CORRESPONDENCES? □ Yes □ No		
EMERGENCY CONTACT PERSON	EMERGENCY CONTACT NUMBER		

DENTAL INSURANCE INFORMATION	
INSURED'S NAME	RELATIONSHIP TO PATIENT
INSURED'S BIRTH DATE	INSURED'S SOCIAL SECURITY NUMBER (MUST HAVE TO FILE CLAIMS)
INSURED'S EMPLOYER	
INSURANCE COMPANY	INSURANCE COMPANY PHONE NUMBER

PLEASE READ CAREFULLY BELOW:

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's needs. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, anxiolytics and other medication as deemed necessary and appropriate for my care. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a full recital of any possible complications. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangement have been made. I further understand that an additional charge may be added to any overdue balance.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

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MEDICAL HISTORY

PATIENT NAME		BIRTH DATE	

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of the 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.

Are you under a physician's care now? □ Yes □ No If yes, please explain _____

Have you ever been hospitalized or had a major operation? □ Yes □ No If yes, please explain _____

Have you had a serious head or neck injury? □ Yes □ No If yes, please explain _____

Have you ever taken a medication containing bisphosphonates (i.e. Fosamax, Boniva, Actonel)? □ Yes □ No If yes, please explain _____

Do you require antibiotics prior to dental treatment? □ Yes □ No If yes, please explain _____

Do you currently, or have you in the past, used Tobacco? □ Yes □ No If yes, please explain _____

Are you taking any medications, pills, or drugs? □ Yes □ No If yes, please list all _____

_____

Are you allergic to any of the following?

□ Aspirin □ Penicillin □ Codeine □ Acrylic □ Metal □ Latex □ Sulfa Drugs □ Local Anesthetics □ Other _____

Women, Are you:

□ Taking oral contraceptives □ Pregnant/Trying to become pregnant □ Nursing

Do you have or have had any of the following? ***(Circle all that apply)***

AIDS/HIV	Cortisone Medicine	Heart Trouble/Disease	Osteoporosis
Anaphylaxis	Diabetes	Hepatitis A	Psychiatric Care
Angina	Drug Addiction	Hepatitis B or C	Radiation Treatment
Arthritis	Easily Winded	Herpes	Sinus Trouble
Artificial Heart Valve	Emphysema	High Blood Pressure	Stroke
Artificial Joint	Epilepsy or Seizures	High Cholesterol	Swelling of Limbs
Asthma	Excessive Bleeding	Hives or Rash	Thyroid Disease
Blood Disease	Fainting Spells/Dizziness	Hypoglycemia	Tuberculosis
Breathing Problems	Frequent Headaches	Leukemia	Tumors or Growths
Cancer-Type	Glaucoma	Liver Disease	Ulcers
Chemotherapy	Heart Attack/Failure	Low Blood Pressure	Venereal Disease
Chest Pains	Heart Murmur	Lung Disease	Parkinsons
Cold Sores/Fever Blisters	Heart Pace Maker	Mitral Valve Prolapse	

Have you ever had any serious illness not listed above? □ Yes □ No If yes, please explain _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ DATE _____

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____ _____
Signature Date

TO DISCLOSE PRIVATE OR ACCOUNT INFORMATION TO PERSONS OTHER THAN THE PATIENT:

I, _____, give permission to Fort Worth Prosthodontics to discuss my patient and account information with the following person(s):

_____ _____
Name Relationship

_____ _____
Name Relationship

_____ _____
Signature Date

Office use only:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practiced, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (specify)_____

Fischer Dental
office@fwpros.com
www.fwpros.com
817-335-3555

FINANCIAL AGREEMENT

Thank you for allowing us to serve you and your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Agreement that we ask that you read and sign indicating you understand and agree to our policies.

1. Fort Worth Prosthodontics is a fee-for-service office therefore the patient is responsible for the full payment at the time of service. For your convenience, we accept cash, checks, VISA, MasterCard and Discover. Should you desire a payment plan, this can be arranged through our third party financing option with MORE MC. There is a $20.00 fee for all returned checks. Please know that your insurance policy is a contract between you and your insurance company and we are not a party to such contracts. Therefore, it is your sole responsibility to call your insurers to inquire about your personal benefits, payments made to your account and/or other insurance related matters. As a courtesy, we are happy to work with your carrier to maximize your benefit and provide you with the documentation you need to receive reimbursement for your treatment.

2. The adult accompanying a minor is responsible for payment at time of service. For unaccompanied minors, non-emergency treatments will be denied unless arrangements for payment have been made prior to the visit. All adults accompanying a minor are asked to remain in the waiting area during treatment.

3. Our practice is not a high-volume practice. The time scheduled for you is just for you. We will make every effort to accommodate your scheduling requests within our normal business hours. In return we ask that you help us by keeping your scheduled appointments or by notifying us at least 24 hours in advance if you are unable to keep your scheduled appointment. In the event that you fail to provide proper notice a charge of $50.00 per scheduled hour will be made to your account.

4. Once you have accepted a definitive treatment plan with Fort Worth Prosthodontics, a retainer fee will be required prior to commencement of treatment. This retainer fee will be discussed with a staff member at the time you accept treatment. If you elect to terminate your treatment after you have commenced treatment, you will *not* be entitled to a refund of the retainer fee paid. The remaining fees associated with your treatment must be paid in full at the time each step of treatment is completed. Often treatment may last over several months, so we encourage our patients to make payments toward your treatment plan prior to the completion date of each step of treatment. Treatment completed and/or services rendered are non-refundable.

5. Once insurance has paid their estimated portion, a statement will be mailed to you. If the balance continues to be unpaid a 3% finance charge will be added until your account is current and paid in full.

Thank you for understanding our financial agreement, and please let us know if you have any questions or concerns. We are all here to care for you.

I have read and I understand the above Financial Agreement and agree to these conditions.

Patient's Name (printed) _____

Signature of Patient or Legal Guardian _____ Date _____