Anne M. Carpenter, D.D.S.

West Houston Doctor's Center
12121 Richmond Avenue, Suite 219 • Houston, Texas 77082
T: (281)497-5001 • F: (281)497-5002
www.AnneCarpenterDDS.com

Anne M. Carpenter, DDS

WELCOME

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ○ Full Time ○ Part Time ○ Retired

Occupation: _____

Hobbies, Interests: _____

Student Status: ○ Full Time ○ Part Time

Pref. Pharmacy _____ Pharmacy Phone: _____

Address _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Relationship: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

City,State,Zip: _____ City,State,Zip: _____

Phone Number _____ Phone Number _____

Group # _____ Member/Subscriber ID _____

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

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 .

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 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 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 ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please List Below*
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following? ◯ Yes ◯ No

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

* Please list all Medications (Including Over the Counter): _____

_____

_____

Please list Name/Address/Phone Number of any/all physicians you are currently seeking medical care:

_____

_____

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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Dental History

1. What is the reason for your visit today?_____
2. Date of last dental visit_____Last dental cleaning_____Last full mouth X-Rays_____
3. What was done at your last dental visit? _____
4. Previous Dentist's Name_____
   Address/State/Zip_____
   Telephone_____
5. How often do you have dental examinations?_____
6. How often do you brush your teeth?_____ How often do you floss? _____
7. Have you ever used or are currently using topical fluoride? .....❒Yes ❒No
8. What other dental aids do you use? (Waterpik, toothpick, etc.)_____
9. **Do you have any dental problems now?** .....❒Yes ❒No
   If yes, please describe._____
10. Check any of the following which apply in either past or present:

❒ Hot or Cold Sensitivity
❒ Sweets Sensitivity
❒ Biting or Chewing Sensitivity
❒ Experience bad odors or bad tastes
❒ Frequent cold sores, blisters or other legions
❒ Bleeding gums
❒ Painful gums
❒ Experienced gum disease
❒ Have tooth loss
❒ Loose teeth
❒ Change in your bite
❒ Food catches between your teeth
❒ Clench or grind teeth while asleep
❒ Clench or grind teeth while awake
❒ Bite lips or cheek regularly
❒ Hold foreign objects with teeth (i.e. pencil)
❒ Mouth breathe while awake or asleep
❒ Snore or other sleeping disorders
❒ Use, smoke, chew tobacco
❒ Orthodontic treatment
❒ Oral Surgery
❒ Periodontal treatment
❒ Your teeth ground or bite adjusted
❒ Received a bite plate or mouth guard
❒ Clicking or popping of jaw
❒ Pain (joint, ear, side of face)
❒ Difficulty opening / closing mouth
❒ Difficulty chewing on either side of mouth
❒ Head, neck, or shoulder aches
❒ Sore muscles (neck, shoulder)
❒ A serious injury to the mouth or head?
If so, please describe, including cause_____
_____
❒ Experience tired jaws, especially in the morning

11. Are you satisfied with your teeth's appearance?.....❒Yes ❒No
12. Would you like to keep all of your teeth all of your life? .....❒Yes ❒No
13. Do you feel nervous about dental treatment? .....❒Yes ❒No
    If so, what is your biggest concern?_____
14. Have you ever had an upsetting dental experience? .....❒Yes ❒No
    Please describe. _____
15. Have you ever been told to take a pre-medication prior to dental treatment? .....❒Yes ❒No
16. Is there anything else you would like us to know? Please describe. _____
    _____
    _____

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.

_____

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Notice of Office Policies

The dental office of Dr. Anne M. Carpenter provides comprehensive dental services to our patients which include cosmetic, restorative, prosthetic, preventative, and other treatments for improving your smile. We are committed to creating and maintaining a beautiful smile that is right for you by offering customized and personalized treatment to fit your dental needs.

Our Mission

Our mission is to deliver to our patients the highest quality of dentistry in the same manner that we would want given to ourselves and our loved ones.

Financial Policy

Authorization to Release Information and Assignment of Benefits:

I certify that I, _____, (or my dependent) have (has) dental insurance coverage and assign directly to Dr. Anne M. Carpenter all insurance benefits, if any, otherwise payable to me for services rendered. I hereby authorize the doctor and/or her staff to release all necessary personal information to my insurance company in order to secure the payment of benefits. I understand that I may inquire about treatment, fees or insurance benefits at any time.

Payments: We accept cash, check, VISA, MasterCard, American Express, Discover, and Care Credit. Payment of your "estimated" portion is due at the time services are rendered, such as your annual deductible and/or percentage of the treatment not covered by insurance. As a courtesy, we will gladly contact your insurance in order to provide an "estimate" of your patient portion. However, despite this, we cannot guarantee the payment of insurance benefits nor can we provide 100% accuracy of this estimated amount since many factors are involved that determine the actual payment of benefits once submitted and processed by your insurance. Keep in mind that many insurance companies base their quoted percentage of coverage (i.e. 100%, 80%, 50%) on their own fee schedule, and not our office's actual fees, which may result in a balance due higher than expected. Should an outstanding balance due result after your insurance company processes your claim, you will then be sent a statement. Payment in full is due by the due date printed on the statement. Our office policy does not allow partial payments. If a credit balance should result after insurance processes your claim, a refund will be promptly issued to you.

Unpaid Insurance Claims: All dental services rendered, whether or not covered by insurance, are ultimately the financial responsibility of the account holder. We will give your insurance company 60 days to remit payment. If there is still no payment after this time, in order to keep your account current, you will be financially responsible for 100% of the outstanding insurance claim. A statement will be sent to you, and payment in full will be due on the due date printed on the statement. It is the responsibility of the account holder to follow up with their own insurance company regarding the non-payment of a claim. Should our office eventually receive a payment from your insurance after it has been paid by you, a prompt refund will be issued.

Past-Due Accounts: If payment is not received by the due date printed on the statement, then your account is considered "past due". We reserve the right to charge a $10.00 per month billing charge on all past due accounts. If the balance is still unpaid after 90 days, the account will be turned over for further collection action. If an account is turned over to our collection agency and/or our attorney for collection, the account holder will be responsible for ALL attorney and/or collection fees that this office incurs while attempting to collect on the unpaid balance. These collection fees will be added to the outstanding portion of the account, and will also become the financial responsibility of the account holder.

Patients without Dental Insurance: Payment in full is expected at the time services are rendered. We accept cash, check, VISA, MasterCard, American Express, Discover and Care Credit.. We are unable to provide discounts if payment is made with a credit card.

Broken/Missed Appointments: We greatly appreciate your efforts in honoring scheduled appointments and wish to provide all of our patients with the highest quality dental care in the most reasonable time possible. We request at least 48 business hours' notice before cancelling or rescheduling an appointment. That way, we have some time to try and fill the opening left in our schedule. *If a patient fails or cancels two (2) scheduled appointments without 48 hours advanced notice, we will institute a broken appointment fee of $50.*

Authorization to Release Information and Treatment:

I authorize release of any information concerning my (or my dependent) health care, advise and treatment to another dentist for evaluating comprehensive oral health.

I authorize the dentist or supervised staff to perform diagnostic procedures, administer medications or anesthetics and treatment as may be necessary for proper dental care.

Dr. Carpenter reserves the right to update and make changes the above-stated office policies at any time without prior notification.

By signing below I verify that I completely understand, agree, and accept the policies outlined above. I further acknowledge that I am responsible for all dental services rendered me and my dependents (if applicable).

Patient Name (print): _____ Date: _____

Responsible Party Signature: _____

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Notice of Privacy Policy

New federal and state regulations require all offices to inform patients and guardians about our particular practices and policies concerning personal information. Private information you share with us will only be used to make treatment decisions individual to you or your child, or in treatment consultations with other doctors helping us make decisions about treatment needs.

If you have insurance and we file that insurance for you, we now need to have written authorization (consent) to divulge information necessary to file that claim. It is our continued policy to only share the minimum information necessary with our insurance processors and insurance companies to file your claim successfully to obtain payment from your insurance company.

In the course of our normal office procedures, you may be called at home or work and left messages about appointments and antibiotic prophylactic and/or antibiotic treatment prior to dental procedures (pre-medication). You may also receive recall cards or other information either by mail, voicemail, email or text message. All lab work not performed onsite will be sent out to an independent lab, we must provide that lab with the patient name and a brief description of the dental case. If you do not wish to receive confirmation/antibiotic regimen calls, recall notices, or have your name released to an independent lab, please notify our business office.

Thank you.

Anne M. Carpenter, D.D.S.

and dental staff

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Acknowledgement of Privacy Policy

PATIENT CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

HIPAA requires that we obtain your consent to use and disclose your protected health information for the purposes of carrying out treatment, obtaining payments, and carrying on healthcare operations for your care.

By signing this consent form you will have acknowledged that you have read our Notice of Privacy Policy/Practices.

You have the right to revoke this Consent by submitting your revocation to us in writing. Any action we took prior to your revocation will not be affected. We may choose to discontinue your treatment if you revoke your consent for us to use and disclose your health information for the reasons stated above.

I, _____, (print your name here) have read the Notice of Privacy Practices and consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

Personal Representative's Name: _____

Relationship to Patient: _____

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

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that any action you took prior to my revocation will not be affected. As a result of my revocation, you may elect to discontinue treating me.

Signature: _____ Date: _____

This document is not a substitution for legal advice