Rayburn General
DENTISTRY

3303 Recreational Road 255 West
Brookeland, TX 75931

Welcome! So that we may provide you with the best possible care, please complete this packet with ALL information lines filled out completely.

PATIENT INFORMATION

Name: _____ **Preferred Name:** _____
First Middle Initial Last

Sex: M__ F__ **Date of Birth:** ____/____/____ **SS#:** _____

DL/ID#: _____ **State:** _____ **Marital Status:** _____

Address: _____
(Street Name and Number) Apt # City State Zip

Best Contact Phone Numbers: (_____) _____ (_____) _____

Email: _____ **Employer Name:** _____

Emergency Contact: _____ (____) _____ **Relation:** _____
Name Phone Number

How did you hear about our office? (Circle One)

Referral: _____ **KJAS 107.3** **KJAS.com** **Our Website** **Family/Friend**
Facebook **Mail-Out** **Yellow Pages** **Driving By**

Other: _____

PARENT/ACCOUNT INFORMATION

Name: _____ **Preferred Name:** _____
First Middle Initial Last

Date of Birth: ____/____/____ **Sex: M__ F__** **SS#:** _____

Address: _____
(Street Name and Number) Apt # City State Zip

Best Contact Phone Numbers: (_____) _____ (_____) _____

Email: _____

Relationship to Patient: Self_____ Spouse_____ Parent_____ Guardian _____ other (explain) _____

Marital Status: _____ **Driver's License #:** _____

Please fill this page out COMPLETELY and answer/circle ALL questions and blanks!

DENTAL HISTORY

- Are you having any immediate dental problems? ____ If so, please explain: _____
- When was your last visit to the Dentist? _____
- When your teeth were last cleaned? _____
- Who was you last Dentist? _____ City: _____ State: _____
- Are you satisfied with your past dentistry? _____Yes _____No
- How often do you brush your teeth? _____ Floss? _____
- Has fear or discomfort kept you from seeing a dentist on a regular basis? ..... Yes No
- Do your gums bleed easily, feel tender or irritated? ..... Yes No
- Are your teeth sensitive to hot, cold or sweets? ..... Yes No
- Do your jaws feel tired or sore? ..... Yes No
- Do you have pain in the head, neck, shoulders or back? ..... Yes No
- Do you have clicking or popping noises when opening or closing your mouth? ..... Yes No
- Are you aware of grinding or clenching you teeth? ..... Yes No
- If so, do you wear a night guard? ..... Yes No
- **In addition to local anesthesia, would you prefer to use the nitrous oxide (laughing gas) or oral / IV sedation?**

Yes **No**

MEDICAL HISTORY

Are you being treated by a physician now? Yes No Reason: _____

Physician's Name: _____ Office Ph#: _____

Address: _____ City: _____ State: _____ Zip: _____

Taking any medication?	Yes	No	Identify: _____
Allergic to any medication?	Yes	No	Identify: _____
Allergic to metals (Example – Nickel)?	Yes	No	Identify: _____
Any recent serious illnesses?	Yes	No	Identify: _____
Have you ever had any major surgery?	Yes	No	Identify: _____
If yes, did you have any complications?	Yes	No	Explain: _____

Please CIRCLE any of the following which you have had or have at present:

Social:

*Alcohol (#/week) _____
*Tobacco (packs/day) _____
*Smokeless Tobacco
*Cocaine/Meth
*Other Recreational Drugs

Health:

*AIDS (HIV+)
*Allergic to Penicillin
*Allergy Any Medicine
*Allergy to Latex
*Arthritis
*Artificial Joint Replacement
*Asthma
*Birth Control Pills
*Bruise Easily
*Blood Clotting Problems
*Prolonged Bleeding
*Cancer
-History of Radiation
-History of Chemotherapy
*Cardiac Problems
-Chest Pains/Angina
-History of Endocarditis
-Heart Murmur
-Artificial Heart Valves
*Currently Pregnant
-Trimester: _____
*Cold Sores/Fever Blisters
*Diabetes
-Type I or Type II
-Hypoglycemia
*Dry Mouth
*Epilepsy/Fainting/Seizures
*Fear of Dental Treatment
*Glaucoma/Eye Disorders
*Hepatitis B or C
*High Blood Pressure
*Kidney/Liver Disorder
*Past Surgical Complications
*Past Anesthesia Complications
*Psychiatric/Psychological Care
*Rheumatic Fever
*Stomach/Intestinal Problems
*Stroke
*Thyroid Condition
*Tuberculosis
*Tumors/Growth
*Ulcers
*Venereal Disease

CONSENT FOR TREATMENT

- I understand that the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the Doctor of any change in my health or medication.
- Upon such diagnosis, I authorize the Doctor to perform all recommended treatment mutually agreed upon by me to employ such assistance as required to provide proper care.
- I agree to the use of anesthetic, sedatives, and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- In some instances, we may require authorization from your medical provider to begin with dental treatment.
- Lastly, I agree to be responsible for payment of all services on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made prior to the services being rendered.

Patient Signature: _____ Date: _____

Parent/Responsible Party Signature: _____ Date: _____

Rayburn General
DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement ****

I, _____, have read and/or received a
(Parent/Guardian or Self)
copy of this office's Notice of Privacy Practices.

_____
{Please Print Patient Name}

_____
{Signature}

_____
{Date}

For Office Use Only

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

☐☐Individual refused to sign

☐☐Communications barriers prohibited obtaining the acknowledgement

☐☐An emergency situation prevented us from obtaining acknowledgement

☐☐Other (Please Specify)

_____
_____
_____
_____
_____

Authorization for Release of Protected Health Information

With your permission, we may disclose your health information to a family member, friend, or other person to obtain help with your healthcare and payment for your care. This form authorizes Rayburn General Dentistry dental providers or staff members to discuss your treatment, appointment, and finances with a designated adult as indicated below.

PLEASE PRINT:

This patient is a: _____ Minor Child _____ Dependent Adult _____Adult 18 years or older

Patient Name: _____

Address: _____

Telephone: _____ Birthdate: _____

Last 4 digits of Social Security Number: _____

I authorize the following persons to receive information about the above named patient concerning dental care, treatment, progress of treatment, and finances. I specifically authorize Rayburn General Dentistry to disclose my Protected Health Information to the following:

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

Name: _____ Phone: _____ Relationship: _____

I may cancel this request at any time by sending a written notice to Rayburn General Dentistry at 3303 RR 255 West, Brookeland TX 75931. I understand that any discussion of information which was made before I cancelled my consent does not mean that my rights to confidentiality were breached.

Patient Name: _____ Signature of Patient/Parent: _____

Date: _____ Relationship to Patient: _____

Rayburn General
DENTISTRY

Late arrival, Cancellation, and "No Show" Policy:

We do our best to see all of our patients in a timely manner, but like all doctor's and dentist's offices in underserved communities, we usually have several emergency calls a day. This causes us to run behind sometimes. For this, we apologize, but we work very hard to stay on schedule. For this reason, the following policies are in place:

- Patients must call within 24 hours of their appointment time to cancel or reschedule; failure to do so 2 or more times might result in dismissal from the practice to allow those patients to find a dentist that can better accommodate their schedules.

- Emergency exams, especially for those who are not already patients of record, will be seen in a timely fashion but those with previously scheduled appointments will be given priority.

- Anyone arriving 10/+ minutes after their appointment time is considered late. As such, we will still try to keep the appointment time in most cases, but this appointment will lose its priority and will be treated as a "work-in" appointment out of respect for those that were able to keep their appointment times. In some cases, we might have to reschedule the appointment for a different day or time.

- Due to our busy schedule, the staff of Rayburn General Dentistry work very hard to confirm the schedule for the next day in order to be sure everyone will keep their appointment times and replace those in the schedule that cannot keep their scheduled appointment time with others so we can see everyone in a timely fashion.

Those patients we cannot confirm for any reason will lose their appointment time. Should a patient on the schedule keep their unconfirmed appointment time, we will honor their original appointment, and will try our best to work them back into the schedule as close to their original appt time as possible. Thank you for your patience as we try to serve the community as best we can.

_____ _____

Patient Name (Please Print) Date

_____ _____

Signature Relationship