golden | FAMILY DENTISTRY

New Patient Information

Please complete all fields. If any item does not apply, please write N/A.

Patient Full Name: _____

Preferred Name (Nickname): _____

Age: _____ Date of Birth: _____ Sex: _____

SSN: _____ Marital Status: _____

Home Address: _____

City: _____State: _____ Zip Code:_____

Cell # _____ Home # _____

Email: _____

Patient's Employer: _____ Work # _____

Primary Doctor's Name: _____

Who may we thank for referring you? _____

Complete ONLY if patient is a minor or student

Mother's Name: _____ DOB: _____

Employer: _____ Work #: _____

SSN: _____

Father's Name: _____ DOB: _____

Employer: _____ Work #: _____

SSN: _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Primary Insurance

Insurance Company's Name: _____

Policy Holder's Name: _____DOB: _____

Employer: _____ SSN: _____

APPLICATION FOR DENTAL TREATMENT

TREATMENT
I hereby apply for acceptance as a patient of **Dr. Lauren Golden**.

I am aware that dental treatment will be rendered by licensed dentists and/or hygienists.

I understand that my treatment will be provided according to the availability of the practitioner.

APPOINTMENTS
I understand that if I fail to pay fees, keep appointments, or cancel appointments less than 24 hours before their scheduled times, I may be charged a $52 cancellation fee and could be dismissed as a patient.

RECORDS/ TEST/ PROCEDURES
I will make known any diseases, allergies, or unusual reactions to drugs or medicines that have occurred to me in the past. If my health or medications change, I will inform the Doctor/Hygienist at my next appointment without fail. I understand that if, during the course of my treatment in this facility, a dentist, hygienist, or employee has an accidental exposure to my blood, a specimen of my blood may be requested and tested for the presence of blood borne diseases. I understand that I may refuse such a blood test and it will not affect my status as a patient. The tests may be done at no charge and will not imply that I carry a disease or am at high risk. The results of such tests or exposure will remain confidential and will not become a part of my permanent record. I will consent to the use of photographs, X-ray films, impressions, and other laboratory diagnostic tests where they are indicated for the purpose of diagnosing and planning treatment. I consent to the use of local anesthetic and other methods of pain control to make me more comfortable while receiving dental treatment.

I understand that unless otherwise arranged, payment for professional service is required on the day the treatment is rendered.

I understand that all original dental records, X-ray films, and diagnostic aids are the property of Dr. Lauren Golden and cannot be taken, or sent, from Dr. Lauren Golden. Copies will be provided upon request of a dentist or physician.

This is to certify that to the best of my knowledge all the preceding answers are true and correct and that I, the undersigned, consent to the performing of any and all dental and oral surgery procedures diagnosed as necessary or advisable by Dr. Lauren Golden and staff, and I will assume responsibility for fees associated with those procedures.

SIGNATURE

_____ _____
SIGNATURE OF PATIENT OR RESPONSIBLE PERSON (AGE 19 OR OLDER) DATE SIGNED (M/D/Y)

_____
PRINTED NAME OF PATIENT

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Dental Insurance & Our Office

As a benefit to our patients, we gladly file your insurance on the day of your appointment. Our fees are reflective of the standard of care we provide. We understand, in today's economy, that extra money is a little harder to come by, so we are extremely thankful for all of our patients who continue to come to our office as an out-of-network provider. Because we are out-of-network, we are not contracted with your insurance company and cannot make any guarantees as to what they will or will not pay.

Our contract is with you, our patient, and we will always respect that relationship. We will provide the best care possible and will continue to be here for you and your family.

Our patients, on the other hand, have two contracts. If you have insurance, you have a contract with the insurance company: you pay your premiums and they pay benefits. You, also, have a contract with our office: we provide a service for a fee and you pay the fee. There is no contract between our office and your insurance company. Your insurance is like a gift card that you can apply towards our fees—the gift card has exclusions and a maximum value. As health care providers, we cannot base your treatment on your "gift card"; we base it on your needs. Dr. Golden does not enter into contracts with insurance companies, because she is dedicated to your health not the insurance company's bottom line. Because of our out-of-network status, there will be times when there is a difference in what we charge and what your "gift card" pays. That difference is your out of pocket expense that we believe is worth the care we provide. We are not here to only provide "gift card" dental health.

We are dedicated to providing you the best oral healthcare we possibly can. Dr. Golden makes recommendations based on her years of clinical experience and countless hours of continuing education. Our team follows her philosophy.

I have read and understand the statements above.

Signature: _____ Date: _____

PATIENT MEDICAL HISTORY

Do you have or have you ever had any of the following conditions (check yes or no):

Y N		Y N		Y N	
☐☐	Abnormal Bleeding	☐☐	Hemophilia		Allergies
☐☐	Acid Reflux/GERD	☐☐	Hepatitis A / B / C (Circle one)	☐☐	Aspirin
☐☐	Arthritis	☐☐	High Blood Pressure	☐☐	Codeine
☐☐	Artificial Joints, if yes, which joint and year of surgery: _____	☐☐	HIV Positive / AIDS	☐☐	Dental Anesthetics
		☐☐	Kidney Problems / Dialysis	☐☐	Erythromycin
		☐☐	Liver Disease	☐☐	Latex
☐☐	Artificial Heart Valve	☐☐	Low Blood Pressure	☐☐	Metals
☐☐	Asthma	☐☐	Mitral Valve Prolapse	☐☐	Penicillin
☐☐	Blood Transfusion	☐☐	Pace Maker	☐☐	Tetracycline
☐☐	Cancer	☐☐	Pneumocystis	☐☐	Tree Nuts
☐☐	Colitis	☐☐	Psychiatric Problems		Other:
☐☐	Congenital Heart Defect	☐☐	Radiation Therapy		_____
☐☐	CPAP	☐☐	Rheumatic Fever		
☐☐	Diabetes, Last A1C _____	☐☐	Seizures		_____
☐☐	Difficulty Breathing	☐☐	Shingles		
☐☐	Drug Abuse	☐☐	Sickle Cell Disease		_____
☐☐	Emphysema	☐☐	Sinus Problems		
☐☐	Epilepsy	☐☐	Sleep Studies		
☐☐	Endocarditis	☐☐	Sleep Apnea		
☐☐	Fainting Spells	☐☐	Stroke		
☐☐	Fever Blisters	☐☐	Thyroid Problems		
☐☐	Frequent Headaches	☐☐	Tuberculosis (TB)		
☐☐	Glaucoma	☐☐	Ulcers		
☐☐	Hay Fever	☐☐	Venereal Disease		
☐☐	Heart Attack	☐☐	Yellow Jaundice		
☐☐	Heart Surgery				

Medications:

Y N

☐☐ Have you ever required antibiotic premedication before dental treatment before?

☐☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, describe below:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

ACKNOWLEDGMENT/CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT GIVING CONSENT-SECTION A.

Name: _____

Address: _____

Telephone: _____ Email: _____

TO PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY-SECTION B.

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 various 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. 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 reserve the right to change our privacy practices as described in our *Notice of Privacy Practices*. If we make any changes to our practices, we will issue a revised *Notice of Privacy Practices*, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our *Notice of Privacy Practices*, including any revisions, at any time by contacting:

Contact: Lauren Golden, D.D.S., PLLC
Phone: 281-328-3525 Email: office@crosbysmile.com
Business Address: 14626 FM 2100 Suite A. Crosby, TX 77532

SIGNATURE

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

If you have decided to decline a copy of this Notice, please initial here and sign below _____

Signature of Patient and/or Patient's Legal Authority to Act on Behalf of said Patient:

_____ Date _____

Printed Name of Legal Authority: _____

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent *will no*t 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.

Declination Signature: _____