NEW PATIENT INFORMATION (This information is necessary for our files and will be considered CONFIDENTIAL.)

Patient 's Name: _____ Age: _____ Birthday: _____
Last First Initial
☐ Male ☐ Female

Minor Patients, Name of Parent or Legal Guardian: _____

Relationship: _____

Address: _____ _____ For how long? _____
Street City Zip

Patient: ☐ Married ☐ Single ☐ Minor ☐ Divorced ☐ Separated ☐ Widowed E-mail:_____

Please provide the following:

Patient or Parent/Legal Guardian if patient is a minor : Cell Phone: (____) _____

Driver's License No.: _____ Social Security No.: _____ Res.Phone: (____)_____

Employed by: _____ How long: _____ Occupation :_____

Employer's Address:_____ _____ Bus. Phone _____
Street City Zip

Spouse 's Name: _____ Driver 's License No.: _____ Social Security No. _____

Employed by: _____ How long: _____ Occupation :_____

Employer's Address:_____ _____ Bus.Phone:_____
Street City Zip

Name or nearest relative not living with you: _____ Relationship : _____

Address: _____ Day Phone No.: _____
Street City Zip

Personal Physician: _____ (_____)_____ ☐ I have no physician
Address Phone

Former Dentist: _____ (____)_____ ☐ I have no dentist
Address Phone

Why are you changing dentists? _____

The purpose of this appointment? _____

Is this dental visit an Emergency? ☐ Yes ☐ No If yes please explain: _____

If you were referred to our office, we would like to thank them. Please give us their name: _____

FINANCIAL INFORMATION

Person responsible for this account: _____ Relationship: _____ (___)_____
Phone

Address: _____ Cell Phone No.:(___) _____
Street City Zip

Name of Primary Insurance Company: _____ _____

Insured Person's Name: _____ Relationship:_____ Date of Birth: _____ SS No.: _____

Name of Dental Group Plan: _____Employer: _____ Group No.: _____ Plan No.: _____

Name of Secondary Insurance Company: _____ _____

Insured Person's Name: _____ Relationship: _____ Date of Birth: _____ SS No.: _____

Name of Dental Group Plan: _____Employer: _____ Group No.: _____ Plan No.: _____

Terms and Conditions:

As a condition of treatment by the office of Gary D. Welch D.D.S., Inc., I understand financial arrangements must be made in advance. This practice depends upon reimbursement from the patient for the costs incurred in their care. Financial responsibility on the part of the patient must be determined before treatment.

All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for in cash at the time service is performed.

I understand that dental services provided to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such credits to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize my insurance company to pay directly to the office of Gary D. Welch D.D.S., Inc. benefits accruing to me under my policy.

A service charge of 1-1/2% per month (18% per annum) (but in no event more than the maximum rate permitted under Texas state law) will be charged on the unpaid principal balance. On all accounts not paid within 60 days of service provided.

I understand that the fee estimate provided for this dental procedure can only extended for a period of six (6) months from patient's examination.

In consideration of the professional services rendered to me, or at my request, by Gary D. Welch D.D.S., Inc. and/or his staff, I agree to pay, therefore, the reasonable value of the services to Gary D. Welch D.D.S., Inc., or his assignee, at the time service are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me, in writing, within the time for payment thereof. Additionally, I agree that a waiver for any breach of any terms or conditions hereunder shall not constitute a waiver of any further terms or conditions. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and /or collection fees.

I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content:

Signed: _____ Print Name: _____ Date: _____

MEDICAL HISTORY

Please answer each question. Your medical history is very important in planning your dental treatment.

1. Are you in good medical health ? ☐ Yes ☐ No
2. Date of your last physical examination _____
3. Are you presently under care of a physician ? ☐ Yes ☐ No
   If you are, what are you being treated for: _____
4. Have you ever been treated for a serious illness or operation ? ☐ Yes ☐ No
   If you have, what illness or operation. _____
5. Have you ever been hospitalized ? ☐ Yes ☐ No
   If you have, what was the problem? _____
6. Are you taking any: ☐ medications, ☐ drugs, ☐ herbs ? ☐ Yes ☐ No
   If you are, what? _____ _____ Dosage: _____
7. Are you using any recreational drugs (i.e. marijuana, cocaine, etc.)? ☐ Yes ☐ No
   If you are, what? _____ _____
8. Have you ever been pre-medicated with antibiotics for your dental treatment ? ☐ Yes ☐ No
9. Are you sensitive or allergic to any drugs or materials ? ☐ Yes ☐ No
   ☐ Aspirin ☐ Codeine ☐ Latex ☐ Penicillin ☐ Sulfa Drugs ☐ Tetracycline ☐ Other _____
10. Do you have or have you had any of the following: (Circle "Y" for YES and "N" for NO)

Y N Acquired Immune Deficiency Syndrome (AIDS)	Y N Chemotherapy	Y N Headaches	Y N Mental Disorder	Y N Stomach Ulcers
Y N Allergies or Hives	Y N Chicken Pox	Y N Head Injuries	Y N Mitral Valve Prolapse	Y N Stroke
Y N Allergies to Metals	Y N Cold Sores	Y N Heart Ailments	Y N Nervous Disorders	Y N TMJ (Temporomandibular Joint) Disorder
Y N Anemia	Y N Congenital Heart Lesions	Y N Heart Attack	Y N Osteoporosis	Y N Thyroid Disease
Y N Angina Pectoris	Y N Cortisone Medicine	Y N Heart Failure	Y N Pain in Jaw Joints	Y N Tonsillitis
Y N Arthritis	Y N Diabetes	Y N Heart Murmur	Y N Psychiatric Treatment	Y N Tuberculosis (TB)
Y N Artificial Prosthesis	Y N Difficulty Swallowing	Y N Hemophilia	Y N Radiation Treatment of any kind	Y N Tumors or Growths
Y N Asthma	Y N Drug Addiction	Y N Hepatitis or Jaundice	Y N Respiratory Disease	Y N Ulcers
Y N Blood Disease	Y N Emphysema	Y N Herpes	Y N Rheumatic Fever	Y N Venereal Disease (Syphilis, Gonorrhea)
Y N Blood Transfusion	Y N Epilepsy or Seizures	Y N HIV Related Complex	Y N Rheumatism	Y N X-Ray or Cobalt Treatments
Y N Bruise Easily	Y N Excessive Bleeding	Y N High Blood Pressure	Y N Scarlet Fever	Y N Other: _____
Y N Cancer	Y N Fainting Spells	Y N Implants	Y N Seizures	
Y N Cerebral Palsy	Y N Glaucoma	Y N Joint Replacement	Y N Sickle Cell Disease	
	Y N Hay Fever	Y N Kidney Disease	Y N Sinus Trouble	
		Y N Liver Disease		

11. Do you have any condition or disease not listed above that you think we should know about ? ☐ Yes ☐ No
    If so, what? _____
12. Do you wear a Cardiac Pacemaker, or have you had heart surgery ? ☐ Yes ☐ No
13. Do you smoke? If you do, how much? ☐ Cigarettes Packs per day _____ ☐ Cigars ☐ Pipe ☐ Yes ☐ No
14. Have you ever taken the drugs ☐ Fen-Phen ☐ Redux or any ☐ diet drugs ? ☐ Yes ☐ No
15. Have you ever taken the drugs ☐ Fosamax ☐ Aridia ☐ Zometa ☐ Boniva ? ☐ Yes ☐ No
16. (Women) Do you take any birth control medication or hormones ? ☐ Yes ☐ No
17. (Women) Do you have any problems associated with your menstrual period ? ☐ Yes ☐ No
18. (Women) Are you Pregnant? If so how many months ? ☐ Yes ☐ No

DENTAL HISTORY

1. Have you ever had a local anesthetic (Novocaine, etc.)? ☐ Yes ☐ No
2. Have you ever had any reaction from a local anesthetic ? ☐ Yes ☐ No
3. Have you had any serious trouble associated with any previous dental treatment ? ☐ Yes ☐ No
   If you have please explain? _____
4. How long since your last full mouth X-Ray? _____
5. How long since your last dental treatment? _____
6. Does dental treatment make you nervous? ☐ Slightly ☐ Moderately ☐ Extremely ? ☐ Yes ☐ No
7. Would you desire to be pre-sedated ? ☐ Yes ☐ No

NOTICE OF PRIVACY PRACTICES

☐ I hereby acknowledge, I have received a copy of Gary D. Welch DDS, Inc. "Notice of Privacy Practices". I further understand that Gary D. Welch DDS,, Inc.'s business office will offer me updates to "Notice of Privacy Practices" should it be amended, modified, or changed in any way.

☐ Patient refusal or was unable to sign because _____

Date: _____ Signature: _____

(A) FIRST VISIT VITALS (Today's Visit)

Hygienist evaluation (Do not write in this area)

Date: _____ B.P. ____/____ PULSE:_____ TEMP.:_____ Notes: _____

Reviewed by: _____ LIC#: _____ Date: _____

(B) UPDATE SINCE YOUR LAST VISIT: (Second Visit)

1. Have you seen a medical doctor ? ☐ Yes ☐ No
2. Have you had a change in your medication ? ☐ Yes ☐ No
3. Have you had a change in your medical condition or had surgery ? ☐ Yes ☐ No

Please describe any health changes since your last visit.

_____

Date: _____ Signature: _____

Hygienist evaluation (Do not write in this area)

Date: _____ B.P. ____/____ PULSE:_____ TEMP.:_____ Notes: _____

Reviewed by: _____ LIC#: _____ Date: _____

(C) UPDATE SINCE YOUR LAST VISIT: (Third Visit)

1. Have you seen a medical doctor ? ☐ Yes ☐ No
2. Have you had a change in your medication ? ☐ Yes ☐ No
3. Have you had a change in your medical condition or had surgery? ☐ Yes ☐ No

Please describe any health changes since your last visit.

Date: _____ Signature: _____

Hygienist evaluation (Do not write in this area)

Date: _____ B.P. ____/____ PULSE:_____ TEMP.:_____ Notes: _____

Reviewed by: _____ LIC#: _____ Date: _____

CONSENT FOR TREATMENT:

I hereby grant authority to Gary D. Welch DDS, Inc. and associate dentist(s) in charge of the care of the patient whose name appears on this "Patient Information and Health History" form, to administer such anesthetics, analgesics, sedatives, nitros oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I will be informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions on the reverse side of this form.

Authorization must be signed by the patient, legal guardian in the case of a minor or a patient that is physically or mentally incompetent.

Signed: _____

Print Name: _____

Date: _____

Relationship to patient: _____

Office Policies
PLEASE READ

Welcome to the office of Welch Dental Group. We are pleased that you have chosen our office to provide dental care to you and your family. Our mission is to provide you with the best dental care possible. In order to make your visit and all future visits with us as pleasant as possible, we would like to take this opportunity to share some information with you.

1. As a courtesy, we will attempt to notify you, usually two-days prior to your appointment, of the date and time of your appointment. **Please make sure that we have current contact information.**

2. Since patients are seen by appointment, please kindly notify us prior to 24 hours of your tentative appointment if you will be unable to keep the appointment. This will allow our staff to offer this time to another patient.

Established patients: Failure to CONFIRM your appointment prior to 24-hours of your appointment time will result in the appointment being cancelled and offered to another patient, if the appointment is for routine cleaning. If you confirm your restorative or hygiene appointment and do not show up, there will be a charge to your account of $50.00.

3. If your child is under the age of 18, of driving age and will be attending the appointment by himself/herself, please be aware that we will need to obtain an authorization from the parent/guardian prior to starting any treatment. **This will require the parent/guardian to attend the initial and possibly subsequent appointments with the child.** Any future visits requiring other than routine care will also require an authorization from the parent/guardian. This authorization must be signed by the parent/guardian before the treatment can be started. If your child comes to an appointment for other than routine care and an authorization for that procedure is not on file, we will ask that your child's appointment be rescheduled. This is done to ensure that you as a parent/guardian are completely informed regarding your child's treatment.

4. Our office is a non-billing office and payment is required at check-out on the day of your visit. Our office does not accept checks as a form of payment.

5. Our office should be notified AS SOON AS POSSIBLE of any changes in insurance, home address, home telephone number and/or work telephone number, and e-mail address. It is extremely important that you notify us at least 2 business days prior to your appointment and any subsequent appointments of any changes in your dental insurance. As a convenience and courtesy to our patients, we accept assignment of benefits. However, in order to do so, we must have ample time to gather certain information from your insurance carrier. Failure to provide this information in a timely manner may prohibit us from utilizing your benefits. Should this occur, we will be happy to file your insurance on your behalf so that you may be reimbursed by the insurance carrier for any benefits available to you.

6. If you have EVER been diagnosed with any of the following: artificial heart valves, history of infective endocarditis, congenital heart conditions, or artificial joints or implants you will be asked to pre-medicate with an antibiotic prior to your appointment unless you bring a release from your physician stating it is not necessary. You will NOT be seen for your appointment otherwise. This is done solely for the safety of you.

7. All patients will incur an asepsis fee (infection control) at each visit. We recommend that you contact your insurance company (if applicable) regarding your financial responsibility for this fee. Payment is due at the time of your visit.

YOU WILL NEED YOUR INSURANCE CARD AND PHOTO ID AT YOUR FIRST VISIT. WE APPRECIATE YOU AS A PATIENT AND LOOK FORWARD TO SEEING YOU SOON!

Thank You,
Welch Dental Group
www.welchdentalgroup.com
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