



dental center of lakewood

6316 gaston avenue, dallas tx 75214
214.823.lake (5253)

Welcome to our office! Thank you for choosing us for your dental care needs. Our goal is to help you maintain your dental health, while providing excellent customer service.

OFFICE HOURS:

Dr. Spillman

Monday, Wednesday and Thursday 8:00am-5:00pm

Dr. Green

Tuesday 8:00am-2:00pm and Friday 8:00am-2:00pm

INSURANCE, FEES, CARECREDIT, AND BILLING

Your insurance policy is a contract between you and your insurance company.

Although our doctors may be contracted with your insurance company, our relationship is with you-not the insurance company. As your dental provider, we will file your claim for you. Your insurance carrier may not approve or reimburse your dental services due to usual and customary rates, benefit exclusions, coverage limits, and lack of authorization or dental necessity. We try to give our best **ESTIMATE** based on the information we have given by your plan. It is **NEVER** a guarantee of payment. We will not become involved in disputes between you and your insurance carrier. **Any remaining balance after insurance sends payment is solely the responsibility of the policy holder/patient.** We do not file secondary dental insurance. We do not offer in-house financing. We use CareCredit to offer extended payment options, which are interest free for 12 months for qualified applicants on amounts of \$200.00 or more.

MISSED OR RESCHEDULED APPOINTMENTS WITHOUT PROPER NOTICE:

Our office does everything possible to remain on schedule. If you are more than 15 minutes late, we may need to reschedule your appointment to another day or time. **We require 24 hours notice when changing, rescheduling, or canceling an appointment. Failure to abide by this policy will result in a charge of \$50.00 per hour per appointment.** This charge will be applied to your account and must be paid before any other appointments can be made. Because we understand that emergencies can happen, the implementation of this fee will be evaluated on a case-by-case basis.

Signature: _____ Date: _____



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1 PATIENT INFORMATION

Date _____
 SS# _____
 Drivers License# _____
 Patient Name _____
 Last Name
 First Name MI
 Address _____
 City _____
 State _____ Zip _____
 E-mail _____
 Sex M F Age _____
 Birthdate _____
 Married Widowed Single Minor
 Separated Divorced
 Patient Employer /School _____
 Occupation _____
 Employer/School Address _____
 Employer/School Phone () _____
 Spouse's Name _____
 Birthdate _____
 SS # _____
 Spouse's Employer _____
 Whom may we thank for referring you? _____

2 DENTAL INSURANCE

Who is responsible for this account? _____

 Relationship to Patient _____
 Insurance Co. _____
 Group # _____
 Insurance Co. Phone# _____
 Subscriber's Name _____
 Birthdate _____ SS# _____

3 PHONE NUMBERS

Home () _____
 Work () _____ Ext. _____
 Cell () _____
 Spouse's Work () _____
 Best time and place to reach you? _____

IN CASE OF EMERGENCY CONTACT
 (Specify someone who does not live in your household.)
 Name _____
 Relationship _____
 Home Phone () _____
 Work Phone () _____

ASSIGNMENT AND RELEASE

I certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr. Spillman all insurance benefits, if any, otherwise payable to me for serviced rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorized the use of my signature on all insurance submissions.

Dr. Spillman may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

 Signature of Patient, Parent, Guardian or Personal Representative

 Please print name of Patient, Parent, Guardian or Personal Representative

 Relationship to Patient

4 DENTAL HISTORY

Reason for today's visit _____

 Former Dentist _____
 City/State _____

Foreign objects	<input type="checkbox"/> Yes <input type="checkbox"/> No
Grinding teeth	<input type="checkbox"/> Yes <input type="checkbox"/> No
Gums swollen or tender	<input type="checkbox"/> Yes <input type="checkbox"/> No
Jaw pain or tiredness	<input type="checkbox"/> Yes <input type="checkbox"/> No

Date of last dental appt. _____

Date of last dental x-rays _____

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- Bad breath Yes No
- Bleeding gums Yes No
- Blisters on lips or mouth Yes No
- Broken fillings Yes No
- Burning sensation on tongue Yes No
- Chew on one side of mouth Yes No
- Cigarette, pipe or cigar smoking Yes No
- Clicking or popping jaw Yes No
- Dry mouth Yes No
- Fingernail biting Yes No

- Lip or cheek biting Yes No
- Loose teeth Yes No
- Mouth breathing Yes No
- Mouth pain, brushing Yes No
- Orthodontic treatment Yes No
- Pain around ear Yes No
- Periodontal treatment Yes No
- Sensitivity to cold Yes No
- Sensitivity to heat Yes No
- Sensitivity to sweets Yes No
- Sensitivity when biting Yes No
- Sores or growths in mouth Yes No

How often do you floss? _____

How often do you brush? _____

5 HEALTH HISTORY

Physician's Name _____ Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine).

Yes No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

- | | | |
|--|--|--|
| AIDS/HIV <input type="checkbox"/> Yes <input type="checkbox"/> No | Fainting/dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No | Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Anemia <input type="checkbox"/> Yes <input type="checkbox"/> No | Glaucoma <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Arthritis <input type="checkbox"/> Yes <input type="checkbox"/> No | Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No | Scarlet Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial heart valves <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No | Shortness of breath <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Artificial joints <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Sinus Trouble <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Hepatitis Type ___ <input type="checkbox"/> Yes <input type="checkbox"/> No | Skin Rash <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Back Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Herpes <input type="checkbox"/> Yes <input type="checkbox"/> No | Special Diet <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Bleeding abnormally, <input type="checkbox"/> Yes <input type="checkbox"/> No | High Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke <input type="checkbox"/> Yes <input type="checkbox"/> No |
| w/extractions or surgery | Jaundice <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen feet/ankles <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Jaw Pain <input type="checkbox"/> Yes <input type="checkbox"/> No | Swollen neck glands <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Thyroid Problems <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemical Dependency <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Tonsillitis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Chemotherapy <input type="checkbox"/> Yes <input type="checkbox"/> No | Low Blood Pressure <input type="checkbox"/> Yes <input type="checkbox"/> No | Tuberculosis <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Circulatory Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Mitral Valve Prolapse <input type="checkbox"/> Yes <input type="checkbox"/> No | Tumor or growth on head or neck <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Congenital Heart Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Nervous Problems <input type="checkbox"/> Yes <input type="checkbox"/> No | Ulcer <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cortisone Treatments <input type="checkbox"/> Yes <input type="checkbox"/> No | Pacemaker <input type="checkbox"/> Yes <input type="checkbox"/> No | Venereal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cough, persistent or bloody <input type="checkbox"/> Yes <input type="checkbox"/> No | Psychiatric Care <input type="checkbox"/> Yes <input type="checkbox"/> No | Weight Loss, unexplained <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Radiation Treatment <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Emphysema <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No | | |

Do you wear contact lenses? Yes No

Women:

Are you pregnant? Yes No

Due date _____

Are you nursing? Yes No

Taking birth control pills? Yes No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone () _____

ALLERGIES

- Aspirin
- Barbituates (sleeping pills)
- Codeine
- Iodine
- Latex
- Local Anesthetic
- Penicillin
- Sulfa
- Other _____

**Dental Center of Lakewood
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**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

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

Please Print 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 acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please Specify)
- _____
