**Panther Creek Dental**
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# NEW PATIENT FORM

## Basic Information

| Name: | | Gender: | |
|---|---|---|---|
| Preferred Name: | | DOB: | |
| SSN #: | | Marital status: | |
| Referral source: | | Employer: | |
| Referred by: | | Occupation: | |

## Contact Information

| Mobile phone: | |
|---|---|
| Home phone: | |
| Email: | |
| | |

## Address Information

| Street address: | |
|---|---|
| City: | |
| State: | |
| ZIP: | |

## Emergency Contact

| Full Name: | |
|---|---|
| Phone number: | |
| Relation: | |
| | |

## Work Information

| Street address: | |
|---|---|
| City: | |
| State: | |
| ZIP: | |

Patient's signature: Date:

Panther Creek Dental
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes. HIPAA provides special protections to certain medical records known as Psychotherapy Notes. All Psychotherapy Notes recorded on any medium by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separately from the rest of the clients medical records to maintain a higher standard of protection. Psychotherapy Notes are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session and that are separate from the rest of the individuals medical records. Excluded from the Psychotherapy Notes definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date. Except for limited circumstances set forth in HIPAA, in order for a medical provider to release Psychotherapy Notes to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other dental records.

8. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

**Panther Creek Dental**
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $50. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

**Panther Creek Dental**
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# COMMUNICATION CONSENTS

## EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Panther Creek Dental offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Panther Creek Dental will use reasonable means to protect the security and confidentiality of email information sent and received. However, Panther Creek Dental cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Panther Creek Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Panther Creek Dental.

Patient's signature: Date:

**Panther Creek Dental**
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

## TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Panther Creek Dental, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Panther Creek Dental will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Panther Creek Dental cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Panther Creek Dental and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Panther Creek Dental.

Patient's signature: Date:

**Panther Creek Dental**
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# HEALTH HISTORY

## | DOB:

### Summary

| | |
|---|---|
| Medical Conditions | **none listed** |
| Allergies | **none listed** |
| Medications | **none listed** |

### General Health Information

| | |
|---|---|
| Are you currently under the care of a physician? | |
| Physician phone number | |
| Date of last physical exam | |
| Are you presently being treated for any injury or illness? | |
| Have you ever been hospitalized for an injury or illness? | |
| Are you pregnant or planning to become pregnant? | |
| Are you currently breastfeeding? | |
| Are you required to pre-med with antibiotics before dental treatment? | |
| Do you use alcohol? | |
| Do you use or have you ever used tobacco? | |
| Have you ever had an allergic reaction? | |

### Medical Conditions

| **Please check all conditions that you have history of or are currently being treated for** | |
|---|---|
| Do you have a history or are currently being treated for any Digestive conditions? | |
| Do you have a history or are currently being treated for any Heart or Circulatory conditions? | |
| Do you have a history or are currently being treated for any Neurological conditions? | |
| Do you have a history or are currently being treated for any Lung or Breathing conditions? | |
| Do you have a history or are currently being treated for any Autoimmune conditions? | |
| Head or neck injuries? | |
| Artificial Joint? | |
| High cholesterol? | |
| History of cancer? | |
| Tumor or abnormal growth? | |
| Radiation therapy? | |
| Chemotherapy? | |
| HIV / AIDS? | |
| Osteoporosis / osteopenia? | |

| | |
|---|---|
| Type I or Type II diabetes? | |
| Anemia? | |
| Kidney disease? | |
| Liver disease? | |
| Thyroid disease? | |
| Tuberculosis / measles / chicken pox? | |
| Any other medical condition we should know of? | |

## Medications

| **Please check all medications you are currently taking** | |
|---|---|
| Are you taking any pain medications? | |
| Are you taking any Antidepressants or Anxiety medications? | |
| Are you taking any Diabetes, Cholesterol, or Blood Pressure medications? | |
| Are you taking any Allergy or Asthma medications? | |
| Are you taking any Antibiotics? | |
| Are you currently taking any other medications or dietary supplements? | |

Patient's signature: Date:

Doctor's signature: Date:

Panther Creek Dental
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# DENTAL HISTORY

## | DOB:

### General Information

| | |
|---|---|
| Who was your previous Dentist and how long were you a patient there? | |
| Date of your last dental exam | |
| Date of your last cleaning | |
| Do you have any immediate concerns you'd like us to address? | |

### Office Relationship

| | |
|---|---|
| What do you value most in your dental visits? | |
| Is there anything you prefer during your visits to make you more comfortable during your time with us? | |
| On a scale from 1-5, 5 being most terrified, are you fearful of dental treatment? | |

### Personal History

| **Please answer the following questions** | |
|---|---|
| Are you concerned about the appearance of your teeth? | |
| Are you interested in improving your smile? | |
| Have you had any cavities within the past 2 years? | |
| Are any teeth currently sensitive to biting, sweets, hot, or cold? | |
| Do you avoid or have difficulty chewing or biting heavily any hard foods? | |
| Do you have any problems sleeping, wake up with a headache or with sore or sensitive teeth? | |
| Do you clench your teeth in the daytime? | |
| Do you wear, or have you ever worn a bite appliance? Either for clenching at night (a night guard) or for sleep apnea? | |
| Do you bite your nails, chew gum or on pens, hold nails with your teeth, or any other oral habits? | |
| Does the amount of saliva in your mouth seem too little or do you find yourself with a dry mouth often? | |
| Have you ever noticed a consistently unpleasant taste or odor in your mouth? | |

### Dental Structural History

| **Please answer the following questions** | |
|---|---|
| Do your gums bleed when brushing or flossing? | |
| Is brushing or flossing typically painful? | |
| Have you ever experienced or been told you have gum recession? | |
| Have you ever been treated for or been told you have gum disease? | |
| Have you had any teeth removed for braces or otherwise? | |
| Do you know of any missing teeth or teeth that have never developed? | |
| Have you ever had braces, orthodontic treatment or spacers, or had a "bite adjustment?" | |

| | |
|---|---|
| Are your teeth becoming more crowded, overlapped, or "crooked?" | |
| Are your teeth developing spaces? | |
| Do you frequently get food caught between any teeth? | |
| Have you noticed your teeth becoming shorter, thinner, or flatter over the years? | |
| Do you have problems with your jaw joint? (TMD, popping, clicking, deviating from side to side when opening or closing?) | |
| Is it often difficult to open wide? | |
| Do you have more than one bite? Or do you notice shifting your jaw around to make your teeth fit together? | |

Patient's signature: Date:

Doctor's signature: Date:

Panther Creek Dental
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# DENTAL INSURANCE INFORMATION

## | DOB:

Created at: **06/18/2022 8:50:30 AM**

### Primary Insurance Information

| | |
|---|---|
| Do you have a dental insurance? | |
| Would you like to upload insurance card photo? | |
| Patient’s relationship to the Insurance Holder | |
| Policy Holder’s Name | |
| Policy Holder’s Date of Birth | |
| Policy Holder’s SSN | |
| Policy Holder’s Address | |
| Policy Holder’s City | |
| Policy Holder’s State | |
| Policy Holder’s ZIP | |
| Policy Holder’s Phone Number | |
| Policy Holder’s Employer | |
| Dental Insurance Company | |
| ID Number | |
| Group Number | |
| Phone number on the back of your insurance card | |
| Address on the back of your insurance card | |

### Secondary Insurance Information

| | |
|---|---|
| Do you have a secondary dental insurance? | |
| That's all! If you would like to add secondary insurance, you need to provide primary insurance first. | |
| Would you like to upload insurance card photo? | |
| Patient’s relationship to the Insurance Holder | |
| Policy Holder’s Name | |
| Policy Holder’s Date of Birth | |
| Policy Holder’s SSN | |
| Policy Holder’s Address | |
| Policy Holder’s City | |
| Policy Holder’s State | |
| Policy Holder’s ZIP | |
| Policy Holder’s Phone Number | |
| Policy Holder’s Employer | |
| Dental Insurance Company | |
| ID Number | |
| Group Number | |

| | |
|---|---|
| Phone number on the back of your insurance card | |
| Address on the back of your insurance card | |

Panther Creek Dental
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

*Powered by Modento*

# GUM DISEASE RISK ASSESSMENT

## | DOB:

### Gum Disease Risk Assessment Questionnaire

Gum Disease Risk Assessment Questionnaire

In our practice, we strive to provide our patients with optimal oral health. We are focused on preventing or limiting periodontal (gum) disease, and dedicated to identifying and treating disease early, when the pain and costs associated with treatment are much less.

According to the National Center for Biotechnology Information, "Significant associations between periodontal disease and cardiovascular disease, diabetes mellitus, preterm low birth weight, and osteoporosis have been discovered, bridging the once-wide gap between medicine and dentistry."

Please take a few minutes to answer the questions below so that we can assess your individual risk for gum disease and tailor our treatment recommendations to your specific needs.

| | |
|---|---|
| Do you floss daily? | |
| Are you age 35 or older? | |
| Do you have a family history of premature adult tooth loss and/or gum disease? | |
| Do you have a history of heart disease and/or are you taking medication for hypertension? | |
| Are you taking medication for diabetes? | |
| Have you ever been a tobacco user (including smokeless tobacco) and/or smoker of any kind (including marijuana/vape)? | |
| Is there redness on toothbrush or in the sink when you rinse after brushing? | |
| Do you have persistent bad breath (noticed by you, your partner/friend/colleague)? | |
| Have you noticed a movement/shifting of teeth (gaps developing, tooth/teeth mobility)? | |
| Do you occasionally experience discomfort/pain when eating/chewing? | |
| Total Points | |

Assessing your Gum Disease Risk

LOW TO MODERATE RISK: Total Points 0-3
MODERATE TO HIGH RISK: Total Points 4-9
HIGH RISK: Total Points 10 or higher

Patient's signature: Date:

Panther Creek Dental
11020 Panther Creek Pkwy Suite #300, Frisco, TX 75035, USA
(202) 468 8164
panthercreekdental.com/

Powered by Modento

# COVID-19 QUESTIONNAIRE

## | DOB:

### COVID 19 QUESTIONNAIRE

This patient disclosure form seeks information from you that we must consider before making treatment decisions in the circumstance of the COVID-19 virus.

A weak or compromised immune system (including, but not limited to, conditions like diabetes, asthma, COPD, cancer treatment, radiation, chemotherapy, and any prior or current disease or medical condition), can put you at greater risk for contracting COVID-19. Please disclose to us any condition that compromises your immune system and understand that we may ask you to consider rescheduling treatment after discussing any such conditions with us.

It is also important that you disclose to this office any indication of having been exposed to COVID-19, or whether you have experienced any signs or symptoms associated with the COVID-19 virus.

| | |
|---|---|
| Do you have a fever or have you felt hot or feverish recently (14-21 days)? | |
| Are you having shortness of breath or other difficulties breathing? | |
| Do you have a cough? | |
| Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? | |
| Have you experienced recent loss of taste or smell? | |
| Are you in contact with any laboratory confirmed COVID-19 positive patients? | |
| Is your age over 60? | |
| Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders? | |
| Have you traveled in the past 14 days to any regions affected by COVID-19? | |

### I CONSENT THAT THE INFORMATION ABOVE IS CORRECT

I fully understand and acknowledge the above information, risks, and cautions regarding a compromised immune system and have disclosed to my provider any conditions in my health history which may result in a compromised immune system.

By signing this document, I acknowledge that the answers I have provided above are true and accurate

Patient's signature: Date: