Gary N. Pointer, DDS

PATIENT INFORMATION

(this information is necessary for our files and is strictly confidential)

Patient's Last Name: ______________________ First Name: ______________ Middle: ______

Home Phone: (   ) ______________ Cell Phone: (   ) ____________ Fax: (   ) ______________

Email Address: ______________________________ Do you check it regularly? Yes ____ No ____

Home Address: ____
Street City State Zip

Date of Birth: __________ Social Security No.: ____________ Driver's License No.: ______________

If a student, name of school: ______________ Whom may we thank for referring you? ______________

Place of Employment: ____

Employer's Address: ____

Occupation: ______________________________ Work Phone: (   ) ______________

FINANCIAL INFORMATION

Name of Person Responsible for this Account: ______________________ Relationship: __________

Street Address: ____________________________________ Phone: (   ) ________
Street City, State, Zip

Social Security Number: ________________________ Date of Birth: ________________

Place of Employment: ____________________________ Work Phone: (   ) ____________

Employer's Address: ____

Is this patient currently a patient in our office: Yes_____ No _____

DENTAL INSURANCE

Insured Person's Full Name: ________________________ Date of Birth: ______________

Social Security Number: ______________ Relationship to Patient: ____________________

Insurance Company Name: ____________________ Group ID Number: ________________

Insurance Company Mailing address for Dental Claims: ________________________________

Employer Name: ____________________ Is there dual coverage for dental claims? Yes _____ No _____

FOR YOUR INFORMATION

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the dental care of the patient named above and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedures involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also understand and agree that any all past due balances over thirty days will be subject to a 1.5% finance charge per month as allowed by Texas state law.

____

Signature of Patient or Responsible Party Date

Gary N. Pointer, DDS

HEALTH QUESTIONAIRE

(this information is necessary for dental treatment and is strictly confidential)

Patient Name: ____

Name of Physician:____Date of last physical: ____________________

City: ____Physician's phone number: (   ) ______________________

Are you allergic to : **Penicillin:** **Yes: ________ No:_________**
Codeine: **Yes: ________ No: _________**
Local Anesthetics: **Yes: ________ No: _________**
Latex: **Yes: ________No:__________**

Other known allergies:____

Have you had any **disease**, i.e. AIDS, HIV, drug or transplant operation that has depressed your immune system?
Yes:________No:__________

Do you have Hepatitis: Yes:________No:__________
If yes, which type: _________________________

Venereal Disease/Herpes: Yes:________No:__________

If female, are you pregnant? Yes: ________No:__________

Have you ever had any prosthetic joint replacements? (Hips, shoulders, knees, etc.)
Yes: _____No:_____

If yes, please explain:
____

Do you have a heart murmur or mitral valve prolapse? Yes: ________ No: _________

Other health complications we should be aware of: ____

Do you wish to speak privately with Dr. Pointer about anything? Yes:__________No:__________

Please list any and all medications you are currently taking and the reasons you are taking those meds:
____

____

Please list any other medical condition you feel Dr. Pointer should be aware of: ______________________________________

____

Please answer all by checking yes or no:	***YES***	***NO***
Heart Problems	_____	______
High Blood Pressure	_____	______
Low Blood Pressure	_____	______
Circulatory problems	_____	______
Rheumatic Fever	_____	______

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Health Questionaire

Patient Name: ____

	YES	***NO***
Diabetes	______	______
Radiation Treatments	______	______
Epilepsy	______	______
Kidney Problems	______	______
Nervous Problems	______	______
Tuberculosis	______	______
Excessive Bleeding	______	______
Cerebral Palsy	______	______
Scarlet Fever	______	______
Malignancies/Cancers	______	______
Chronic Sinus	______	______
Chronic Ear Problems	______	______
Anemia	______	______
Arthritis	______	______
Adenoids removed	______	______
Tonsils removed	______	______
Asthma	______	______

Name of Previous Dentist: _________________________________City/State:__________________________________

Date of last visit: __________________________________Reason for last visit:__________________________________

Are you sensitive to: Heat: ______ Cold:________ Sweets: ________ Chewing/Pressure:________

Have you had any injuries to the mouth/jaw area? ____

When were your last dental x-rays? _____________When was your last cleaning and exam?______________________

Do your gums bleed or feel tender or irritated? Yes:_____ No:______

Have you ever had periodontal treatments/surgery? Yes: _____ No:______

If Yes, please explain: ____

Do you smoke or use tobacco products? Yes:________ No:_________

Do you wear dentures/partials? Yes:______No:________

Are you aware of grinding or clenching your teeth? Yes:_______ No:_______

Do you have discolored teeth that bother you? Yes:_______ No:_______

Are there any other dental concerns you would like Dr. Pointer to be aware of:________________________________

____

I hereby acknowledge that I have provided the above health information to Dr. Gary Pointer and that it is true and accurate.

____
Patient Signature or Guardian Relationship Date

Gary N. Pointer, DDS

Assignment of Insurance Benefits

In consideration of services rendered, I hereby transfer and assign to Gary N. Pointer, DDS, 4901 Bryant Irvin Rd. North, Fort Worth, Texas, all right, title and interest in any payment due for services as provided in the policy or policies of dental insurance held by me.

I agree to pay, at Fort Worth, Tarrant County, Texas the charges of Gary N. Pointer, D.D.S., which exceed the amount paid by the insurance policies held by me. I further agree and authorize Gary N. Pointer, D.D.S., to release any information requested by the insurance company(s) or its representatives. I understand that filing of my dental insurance is done as a courtesy to me.

Authorization for Treatment

I hereby authorize Gary N. Pointer, D.D.S., to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient named below and further authorize and consent that Dr. Gary Pointer chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by Dr. Pointer and /or his staff. I further authorize the use of any study models, photographs or radiographs taken by Dr. Pointer to be used by him for educational or teaching purposes.

Agreement to Pay for Services Rendered

I agree to pay for all services rendered by Dr. Gary N. Pointer. I further understand that I am legally responsible for all cost of treatment, regardless of any estimated insurance balance. I also understand and agree that any and all past due balances over thirty (30) days will be subject to a finance charge of 1.5% (18% annually) per month, as allowed by the laws of the State of Texas.

I also acknowledge that I have received a copy of the Notice of Privacy Practices (HIPAA).

I hereby authorize Gary N. Pointer DDS, to release dental information regarding myself by mail, on my answering machine or voice mail. Patient's Initials: _____________

Print Name of Patient: ____________________________________

Authorized Signature: ____Date: _______

I hereby authorize Gary N. Pointer, DDS to release dental/medical information regarding myself to the following:

Name:	Relationship	Phone #	Patient Initials