

**SETH ATKINS, DDS, PLLC**  
110 PARK PLACE CT, STE 100  
WAXAHACHIE, TEXAS 75165  
Phone: 972-937-8433

**Thank you for selecting our dental practice as your dental care provider!  
We welcome you and will make every effort to provide you with ultimate dental care.**

### **General Office Policies**

1. Our office hours are Monday through Thursday 8:00 a.m.–5:00 p.m.
2. Our Practice is built on preventive care and maintenance of oral health.
3. If you are a new patient and are not experiencing pain, your first visit will include:
  - \*Comprehensive Health History
  - \*Necessary X-Rays
  - \*Assessment by Dental Hygienist
  - \*Oral Exam by Dr. Atkins
4. Further dental treatment will be discussed and scheduled after this visit.
5. A plan for preventive dentistry will be designed just for you. We recommend regular visits at least every 6 months or more often if advised by our staff. Preventive care is the best care!
6. Patients should always be ready to provide current medications and any changes in general health.
7. Payment is due at the time of service. MasterCard, Visa, Discover, American Express, Personal Check or Cash are accepted. Financing options are available through Care Credit. As a courtesy to you, we will be glad to file your insurance with proper documentation,

**Our greatest concern is your complete oral health. We look forward to serving your dental needs and welcome referrals.**

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**Financial and Scheduling Policies**

Payment is due at the time of service. MasterCard, Visa, Discover, American Express, Personal Check or Cash are accepted. Financing options are available through Care Credit and Capital One.

Insurance will be filed as a courtesy to our patients with proper documentation provided.

1. Copy of the current insurance card
2. Employer name, address and phone number.
3. Policyholder's name
4. Policyholder's social security number or insurance ID and date of birth.
5. Group number

The patient is responsible for all charges not covered by the insurance. Unpaid dental claims are the patient's responsibility within 30 days from date of service.

I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment.

I understand that if my account balance is overdue I will be reported to the credit bureaus. Any professional collection costs incurred will be added to my balance and will be my responsibility.

**Photography Release**

I \_\_\_\_\_, hereby authorize Dr. Seth Atkins and his staff to take photographs, slides, and / or videos of my face, jaws, and teeth.

I understand that the photographs, slides, and / or videos will be used as a record of my care, for communication with other specialists (if indicated) and may be used for educational purposes in lectures and/or presentations. Your privacy is always our chief concern. Appropriate measure are always taken to conceal patient identity and any identifying information is removed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

# PRIVACY PRACTICE ACKNOWLEDGEMENT AND CONSENT FORM FOR PATIENT

**SETH ATKINS, DDS, PLLC**  
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WAXAHACHIE, TEXAS 75165

I understand that, under the Health Insurance Portability & Accountability Act of 1996(HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used, but it is not mandatory for me to sign in order to:

- \*Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- \*Obtain payment from third-party payers.
- \*Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given a copy of your Notice of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bonded to abide by such restrictions.

I understand that I may revoke this consent in writing at anytime, except to the extent that you have taken action relying on this consent.

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

DOB \_\_\_\_\_

PATIENT NAME \_\_\_\_\_

SIGNATURE \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_

DATE \_\_\_\_\_

# PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Sex: \_\_\_\_\_ Age: \_\_\_\_\_

Home address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Billing address (if different): \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Cell: \_\_\_\_\_ E-mail: \_\_\_\_\_ Driver's license #: \_\_\_\_\_ State: \_\_\_\_\_

SS #: \_\_\_\_\_ Employer/Occupation: \_\_\_\_\_ Bus. Phone: \_\_\_\_\_

Spouse's name & phone #: \_\_\_\_\_ Emergency phone # (other than spouse): \_\_\_\_\_

Primary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Secondary dental insurance: \_\_\_\_\_ Group #: \_\_\_\_\_

Subscriber's name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SS #: \_\_\_\_\_

Name of your medical doctor: \_\_\_\_\_ Date of last visit to medical doctor: \_\_\_\_\_

Name of previous dentist: \_\_\_\_\_ Date of last visit to dentist: \_\_\_\_\_

Referred to us by: \_\_\_\_\_

## DENTAL HEALTH HISTORY

	Yes	No		Yes	No
Are you apprehensive about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush?	_____	_____
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss?	_____	_____
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise so that it bothers you or others?	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open freely?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of the ears?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awaking in the morning?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a temporomandibular (jaw) disorder (TMD)?	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want?	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids?	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite?	<input type="checkbox"/>	<input type="checkbox"/>
Sours?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)?	<input type="checkbox"/>	<input type="checkbox"/>
Sweets?	<input type="checkbox"/>	<input type="checkbox"/>	Are you a habitual gum chewer or pipe smoker?	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements?	<input type="checkbox"/>	<input type="checkbox"/>			
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>			
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>			

**MEDICAL HISTORY**

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

Women: Are you  
Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_