ReeseDental at Lake Country

Royce W. Reese, DDS

WELCOME TO OUR PRACTICE, PLEASE FILL OUT THE FOLLOWING:

PATIENT INFORMATION:

PATIENT'S LEGAL NAME:_____
Last First Middle Preference

ADDRESS:_____
STREET APT# CITY STATE ZIP CODE

HOME PHONE:_____CELL#:_____

MAY WE LEAVE A MESSAGE ON YOUR CELL PHONE? Y N
MAY WE CONTACT YOU VIA TEXT: Y N

EMAIL ADDRESS:_____ MAY WE CONTACT YOU VIA EMAIL? Y N

BIRTHDATE:_____ MALE /FEMALE:_____ MARITAL STATUS:_____

SOCIAL SECURITY#:_____ DRIVERS LICENSE #:_____ STATE:_____

HOW WERE YOU REFFERRED TO OUR OFFICE:_____

RESPONSIBLE PARTY

PRIMARY INSURANCE INFORMATION

INSURED'S NAME::_____
Last First Middle Preference

SOCIAL SECURITY#_____ BIRTHDATE:_____ INSURED'S EMPLOYER:_____
INSURANCE CO:_____ GROUP NUMBER_____ INSURANCE PHONE#:_____
INSURANCE ADDRESS:_____
STREET APT# CITY STATE ZIP

SECONDARY INSURANCE INFORMATION:_____

SIGNATURE:_____
BY SIGNING ABOVE YOU ACHNOWLEDGE THAT YOU ARE RESPONSIBLE FOR THIS ACCOUNT.
SPOUSES NAME:_____ DOB:_____ SOCIAL SECURITY#:_____
ADDRESS:_____
STREET APT# CITY STATE ZIPCODE
EMAIL ADDRESS:_____ MAY WE CONTACT VIA EMAIL? Y N

HOME PHONE:_____ WORK PHONE:_____CELL#:_____

EMERGENCY CONTACT INFORMATION:
NAME OF NEAREST RELATIVE NOT LIVING WITH YOU:_____ PHONE:_____

ADDRESS:_____
STREET APT# CITY STATE ZIPCODE

It is important that I know about your medical and dental history. These facts have a direct bearing on your dental health. This information is strictly confidential and will not be released to anyone. Thank you for taking the time to completely filling out this questionnaire.

DENTAL HISTORY	***YES***	***NO***
HOW LONG SINCE you have seen a dentist?		
Last COMPLETE Dental Exam Date:		
Last full MOUTH X-RAYS, DATE: (INCLUDING PANORAMIC)		
Are you having dental PROBLEMS now?		
What?		
Is your present dental health POOR?		
Do you wear DENTURES?(Partials or Full)		
Are you UNHAPPY with your dentures?		
Would you like to know more about PERMANENT REPLACEMENTS?		
Are you APPREHENSIVE about dental treatment?		
Have you had any PERIODONTAL (GUM) treatments?		
Do your gums BLEED, or feel TENDER or IRRITATED?		
Are your teeth SENSITIVE to hot, cold, sweets, pressure?		
Are you UNHAPPY with the APPEARANCE of your teeth?		
Are you aware of CLENCHING or GRINDING your teeth?		
Do you have HEADACHES, EARACHES or NECK PAINS?		
Have you worn BRACES on your teeth?(ORTHODONTICS)		
Do you have DISCOLORED teeth that bother you?		
Are you interested in COSMETIC DENTISTRY?		
Do you regularly use DENTAL FLOSS?		
Name of previous dentist?		
City: State:		
How do you feel about your teeth?		

Please RANK the following in the order in which they would KEEP YOU FROM having dental treatment.

FEAR of pain	#	LACK of Concern	#
Cost of treatment	#	Missing work time	#

MEDICAL HISTORY	YES	NO
Do you have any CURRENT HEALTH PROBLEMS?		
Are you under a PHYSICIANS CARE now?		
For What?		
What MEDICATIONS are you currently taking? (List all)		
Are you PREGNANT or NURSING?		
Do you SMOKE?		

Circle any of the following which you have had or presently have:

A.I.D.S./A.R.C./ HIV Positive
Alcoholism
Allergies or Hives
Anemia
Angina Pectoris
Artificial Heart Valve
Artificial Joint (Hip, Knee)
Arthritis
Asthma
Bruise Easily
Blood Transfusion
Congenital Heart
Chemotherapy (Cancer, Leukemia)
Cosmetic Surgery
Cortisone Medicine
Diabetes
Drug Addiction
Emphysema
Eplepsy or Seizures
Fever Blisters
Glaucoma
Hay Fever
Heart Disease or Attack
Heart Pacemaker
Heart Murmur
Heart Surgery
Hemophilia (bleeding problems)
Hepatitis A (infectious)
Hepatitis B (serum)
High Blood Pressure
Kidney Trouble
Lesions
Liver Disease
Nervousness/Depression
Pain in Jaw Joints
Psychiatric Treatment
Radiation Treatment
Rheumatic Fever
Sinus Trouble
Stroke
STD/Venereal Disease
Thyroid Disease
Tuberculosis (TB)
Ulcers:_____
Venereal Disease

ARE YOU ALLERGIC TO OR HAVE YOU REACTED ADVERSELY TO ANY OF THE FOLLOWING MEDICATIONS?

Aspirin	Local Anesthetic	Erythromycin
Nitrous Oxide	Codeine	Penicillin
		Latex

Are you aware of being allergic to any other medication or substance? _____
If yes, please list:_____
Is there any other Medical or Dental information that you feel I should know about?

Family Physician:_____ ph:_____

I AUTHORIZE DOCTOR ROYCE W. REESE, DDS AND STAFF TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS, OR ANY OTHER DIAGNOSTIC AIDES DEEMED APPROPRIATE BY DOCTOR ROYCE W. REESE TO MAKE A THOROUGH DIAGNOSIS OF MY DENTAL NEEDS. I ALSO AUTHORIZE DOCTOR ROYCE W. REESE TO PERFORM ALL RECOMMENDED TREATMENT MUTUALLY AGREED UPON BY ME, AND APPROPRIATE MEDICATION AND THERAPY INDICATED OR SUCH TREATMENT. I UNDERSTAND THAT USING ANESTHETIC AGENTS EMBODIES A CERTAIN RISK. FUTHERMORE I AUTHORIZE AND CONSENT THAT DOCTOR ROYCE W. REESE CHOOSE AND EMPLOY SUCH ASSISTANCE DEEMED FIT TO PROVIDE RECOMMENDED TREATMENT.

SIGNATURE:_____DATE:_____

Royce W. Reese, DDS
8525 Boat Club Rd
Fort Worth, Texas 76179
Phone: 817-500-5288
Fax: 817-385-6719

OUR FINANCIAL POLICY

Any question regarding fees will be explained upon request and the patient shall decide upon a payment plan.

Indicate your choice of payment today by circling option #1 or option #2.
(This payment includes any applicable insurance percentage.)

OPTION #1: Cash or CARECREDIT – (We no longer accept CHECKS).
OPTION #2: VISA, MasterCard, American Express or Discover charge cards.

INSURANCE INFORMATION

Your insurance policy is a contract between you and your insurance company. We are not a part to that contract. The balance due is your responsibility whether your insurance company pays or not. Even though an insurance claim is filed, you will receive a statement each month if you have a balance due. If your insurance company has not paid in full within 60 days, the balance automatically becomes your responsibility and payment in full is expected within 30 days of receiving your statement. In the event that payment is not made on time, there will be a billing charge and or finance charge of 1 1/2% added to your account. Please be aware that some, and perhaps all, of services provided may be "non covered" services and may not be considered under your dental insurance. You are responsible for payment in full regardless of any insurance company's arbitrary determination of usual and customary rates.

Please initial each of the following statements:

This office cannot be responsible for collecting your claim or for negotiating a settlement on a disputed claim.

_____ Initial

If an insurance claim is not paid within 60 days, payment in full becomes your responsibility.

_____ Initial

Insurance: I authorize Royce W. Reese, DDS and/or staff to release my records to appropriate insurance companies. I also authorize Royce Reese and/or staff to file an appeal on my behalf if needed thru my insurance company or the TDI or whatever department necessary.
Payments of Benefits: I authorize payments of benefits as determined by my insurance company directly to Royce W. Reese, DDS/Reese Dental at Lake Country.

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is vital to our professional relationship. If you have any questions about our policy please ask us before treatment is started and we will be glad to assist you.

I have read the financial policy and agree with the terms.

Signature:_____ Date:_____

Acknowledgement of Receipt of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

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

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

Royce W. Reese, DDS
8525 Boat Club Rd
Fort Worth, Texas 76179
Phone: 817-500-5288
Fax: 817-385-6719

Missed/Cancellation Appointment Policy

Office hours are by appointment and we do value your time. This office is a private practice dental office. Appointment time is reserved for you alone. Where appropriate, we prefer to schedule longer appointments so we can complete as much needed dental treatment as possible during one appointment. We feel this type of scheduling will cause minimal disruption to your daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure that you will be able to keep it. Emergencies and unforeseen patient treatment problems may arise, causing schedule changes. Emergencies are unexpected and seem to come at the most inconvenient times. If you have a dental emergency that needs immediate attention, we will always offer to see you at once. We expect that other patients who might be slightly inconvenienced by this will be understanding of the situation. At some point, they may need the same courtesy too! Like many offices, this office does call to confirm your appointment. Please make a note of any dental appointments we have scheduled in a place where you will be easily reminded. If you cannot make an appointment as scheduled, please notify the office. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call at least 72 hours in advance. Appointments are in high demand, and your early cancellation will allow another patient access to timely dental care***. Appointments not cancelled 3 days in advance will result in a $50 cancellation fee. Saturday appointments will result in a $50 cancellation fee regardless of reason of cancellation.***

To cancel your appointment, please call 817-500-5288. If you do not reach us, you may leave a detailed message on our voice mail. If you would like to reschedule your appointment, please leave your name and phone number. We will return your call promptly.

Appointment Cancellation Policy Agreement

I agree to call Reese Dental at (817) 500-5288 by 2:00 p.m. 3 days prior to my scheduled appointment to notify of any changes or cancellations. To cancel *Monday* appointments, I will call Dr. Reese's office by 2:00 p.m. on Wednesday. If prior notification is not given I will be charged $50.00 fee for the missed appointment. By signing this consent I agree to these terms. Furthermore I understand that Saturday appointments will result in a $50.00 cancellation fee regardless of the reason of cancellation.

Please sign below to consent to these terms.

_____ _____

Patient Signature/ (Parent/Guardian if under 18) **Date**

If you have any questions about our appointment cancellation and no-show policy, please feel free to ask us.