



**Health History Pg.1**

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[www.bspdentistry.com](http://www.bspdentistry.com)

Chart# \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ SSN \_\_\_\_-\_\_\_\_-\_\_\_\_

Address \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_

Sex \_\_\_M\_\_\_F Marital Status \_\_\_\_\_ Email \_\_\_\_\_

Employer Name \_\_\_\_\_ Address/Zip \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

**DENTAL Insurance Policy Holder's Information-**

Name: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

(IF MILITARY, SPONSOR'S RANK: \_\_\_\_\_)

Insurance Company Name: \_\_\_\_\_ Group #: \_\_\_\_\_

ID# \_\_\_\_\_ **Has your insurance changed since last visit?  Yes  No**

\*Guardian Name: \_\_\_\_\_ Guardian DOB: \_\_\_\_\_ SSN \_\_\_\_\_

(\*IF OTHER THAN PATIENT)

Guardian Address: \_\_\_\_\_ City/State \_\_\_\_\_ Zip \_\_\_\_\_

Guardian's Relationship to Patient \_\_\_\_\_

**Yes No** Please Mark **YES** or **NO** to the Following:

- ARE YOU CURRENTLY PREGNANT (WOMEN)?
- DO YOU HAVE A HEART CONDITION?
- HAS A PHYSICIAN RECOMMENDED ANTIBIOTICS PRIOR TO DENTAL TREATMENT? (i.e. FOR JOINT REPLACEMENT, HEART MURMUR, ETC...)
- DO YOU HAVE HIGH BLOOD PRESSURE?
- DO YOU HAVE DIABETES?
- DO YOU HAVE MITRAL VALVE PROLAPSE?
- HAVE YOU EVER HAD RHEUMATIC FEVER?
- HAVE YOU EVER HAD HEPATITIS?
- HAVE YOU EVER TESTED POSITIVE FOR HIV?

Bourland~Soben Dentistry

Health History Pg. 2 Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Chart #: \_\_\_\_\_

Yes No Please Mark YES or NO to the Following:

- HAVE YOU HAD JOINT REPLACEMENT SURGERY?
- ARE YOU ALLERGIC TO NICKEL OR BERYLLIUM?
- HAVE YOU EVER HAD TUBERCULOSIS (TB)?
- ARE YOU CURRENTLY OR HAVE YOU USED TOBACCO PRODUCTS?
- ARE YOUR TEETH SENSITIVE TO HOT? \_\_\_\_\_ COLD? \_\_\_\_\_ SWEETS? \_\_\_\_\_
- ARE YOU AWARE OF GRINDING OR CLINCHING YOUR TEETH? \_\_\_\_\_
- DO YOU SUFFER FROM CHRONIC HEADACHES? IF SO WHERE? \_\_\_\_\_
- LIST ANY ALLERGIES? \_\_\_\_\_
- ARE YOU RECEIVING MEDICATION OR CARE FROM ANY OTHER HEALTHCARE PROVIDER? (Yes/No) \_\_\_\_\_ NAME OF PROVIDER \_\_\_\_\_  
REASON FOR CARE/TREATMENT \_\_\_\_\_  
LIST ALL DRUGS OR MEDICATIONS YOU ARE PRESENTLY TAKING or PLEASE PROVIDE US WITH A LIST  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you ever had radiation treatment? Y N If so when? \_\_\_\_\_ What area? \_\_\_\_\_

In case of Emergency, Notify: \_\_\_\_\_ Phone: \_\_\_\_\_

Patient (or Legal Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If Minor: Legal Guardian Name (PRINT): \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

**For Office Use Only:**

Front Office Name: \_\_\_\_\_ Assistant/Hygienist Name: \_\_\_\_\_

Doctor Name:  Bart Bourland, DDS  Wes Soben, DDS Doctor Signature \_\_\_\_\_

Doctor's Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Bourland-Soben and Partners Cosmetic & Family Dentistry  
**Dental Health Information**

Thank you for providing us with Important Information that will help us serve you better.

Are you having any discomfort? Yes No **Patient's Name:** \_\_\_\_\_

Any sensitivity to hot, cold, sweets, chewing? Yes No **Patient's Date of Birth:** \_\_\_\_\_

Does dental treatment make you nervous? Yes No **Patient's Chart #:** \_\_\_\_\_

**Have you experienced any of the following problems?**

Bleeding Gums	yes	no
Bad breath	yes	no
Soreness in jaw joint	yes	no
Grinding your teeth	yes	no

**On a Scale of 1 to 10 being the highest rating, circle one:**

How important is your dental health to you?  
1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?  
1 2 3 4 5 6 7 8 9 10

Where would you like your dental health rating to be?  
1 2 3 4 5 6 7 8 9 10

Do you think your dental health effects your overall health? Yes No

How often do you have your teeth cleaned? \_\_\_\_\_

When was the last time you had an oral cancer exam? \_\_\_\_\_

Is the brightness of your teeth important to you? Yes No

Do you smoke or use tobacco in any form? Yes No

How many soft drinks or sweet drinks do have daily? \_\_\_\_\_

**If you could change anything about your teeth-  
would you make them?**

Whiter	yes	no
Straighter	yes	no
Close Spaces	yes	no
Replace black fillings with tooth colored ones	yes	no
Repair chipped teeth	yes	no
Replace missing teeth	yes	no
Replace old crowns or caps that don't match	yes	no
Have less gum showing	yes	no
Be able to chew better	yes	no

Have you had any teeth removed? yes no

Has a dentist or hygienist ever made you feel uncomfortable about your teeth or home care? Yes No

If there were a way to whiten your teeth for a reasonable investment, would you be interested? Yes No

What is the most important thing to you about your future smile and dental health? \_\_\_\_\_

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**  
**Bourland~Soben Dentistry**

**PRINT Patient Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ Chart #: \_\_\_\_\_

By signing below, I am acknowledging that:

- I am either the patient or the patient's personal representative;
- I have received a copy of the "Notice of Privacy Practices" for Bourland~Soben Dentistry; and
- I understand that I may contact the person named in the Notice if I have questions about the content of the Notice.

**IF MINOR-** PRINT Parent/Guardian Name: \_\_\_\_\_

(Relationship to Patient: \_\_\_\_\_)

**Patient / Parent / Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

# Bourland-Soben and Partners Cosmetic & Family Dentistry

Bart Bourland DDS Wes Soben DDS

## Patient Agreement

Dear Patient,

We want to take this opportunity to welcome you to our fine family of patients, and thank you for choosing our office to care for your dental needs. We will strive to do everything possible to provide you with the best dental care and the highest quality service available.

We, in turn, expect 3 things from our patients:

1. Keep scheduled appointments and arrive on time. If an event absolutely requires a cancellation, please call our office with 48 hours notice. This time is set aside especially for you and without sufficient notice; it creates a significant void in our schedule which someone else could have used. **All minors (under age 18) must be accompanied by a parent or guardian at each dental appointment, unless prior arrangements have been made with Bourland-Soben and Partners.**
2. Honor any financial commitment. We would ask that patients pay for all services in full at the time they are rendered, unless financial arrangements have been made with our Financial Secretary before treatment is started. We accept most insurance, AFTER it has been pre-certified. We also accept MasterCard, Visa, Discover, and Care Credit.
3. Refer new patients if you are pleased with our services.

If ever an occasion arises where you are not completely satisfied with your service or care from us, feel free to call us or you may contact the Texas State Board of Dental Examiners, (TSBDE), at 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701-3942 or you can call TSBDE at 800-821-3205. Always let us know if you have a question regarding your care or treatment.

Once again, WELCOME! We do hope that your visits to our office will always be as pleasant as possible.

If you are truly satisfied with your service, remember that the greatest compliment any of our patients could ever give us is to refer a friend or family member to our practice.

Thank you,

Dr Bourland, Dr. Soben and Staff

I have read and understand the Patient Agreement.

**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_

**Legal Guardian Name (Print):** \_\_\_\_\_

**Patient or Legal Guardian (Signature):** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Bourland-Soben and Partners Cosmetic & Family Dentistry**  
Bart Bourland DDS      Wes Soben DDS  
**GENERAL INFORMED CONSENT FOR DENTAL PROCEDURES AND ANESTHESIA**

This is my consent for Dr. Bourland, Dr. Soben, or any other physician who may be necessary, to perform the oral, maxillo-facial, and/or dental procedures indicated on my examination chart and any other procedure deemed necessary as a corollary to the planned sedation, and/or ultra light general anesthesia depending upon the judgment of the doctors involved in my care.

I have been informed and understand that occasionally there are complications that can occur with any dental procedure, including surgery, anesthesia, and or medications. These include but are not limited to the following:

- Post operative discomfort and swelling
- Heavy bleeding that may be prolonged
- Post operative infection requiring additional treatment
- Bruising or discoloration at the injection site
- Injury to the nerve underlying the teeth resulting in numbness or tingling of the chin, lip, cheek, gums and/or tongue on the treated site; this may persist for weeks, months, or in remote instances, permanently
- Stiffening of the neck and facial muscles
- Restricted mouth opening for several days or weeks
- Thrombophlebitis (inflammation of a vein) from intravenous and intramuscular injections
- TMJ injury secondary to treatment, especially when TMJ symptoms pre-exist
- Change in occlusion
- Injury to the adjacent teeth, restorations in other teeth, and injury to other tissues
- Referred pain to the ear, neck and head
- Nausea and vomiting, allergic reaction, cardiovascular collapse or other conditions requiring hospitalization
- Oral/sinus openings with delayed healing and possibly requiring additional surgery
- Decision to leave a small piece of root in the jaw when its removal would require extensive surgery

Anesthetics, medications, and prescriptions may cause drowsiness and lack of coordination, which can be decreased by the use of alcohol or other drugs. I have been advised not to operate any vehicle or hazardous device for at least 24 hours or until fully recovered from the effect of the anesthetic or medications that may have been given to me for my care.

During the course of my treatment, unforeseen conditions may be revealed that necessitate an extension of the original procedure or a different procedure than first planned. I therefore authorize and request Dr. Bourland, Dr. Soben, and their assistants to perform such procedures as are necessary and desirable in the exercise of their professional judgment. The authority granted under this paragraph shall extend to the treatment of all conditions that require treatment and are not known at the time the original procedure is commenced.

All post operative instructions will be explained to me along with receiving written instruction. I will arrange for a post operative visit if necessary and I understand that a perfect or cure is not guaranteed or warranted and cannot be guaranteed or warranted. I also understand that I may ask for a full recital of all possible risks attendant to phases of my care by just asking.

If you have any complaints you may contact the Texas State Board of Dental Examiners, (TSBDE), at 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701-3942 or you can call TSBDE at 800-821-3205.

**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ Chart #: \_\_\_\_\_

**Legal Guardian Name (Print):** \_\_\_\_\_

**Patient or Legal Guardian (Signature):** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

**Office Rep Name (Print)** \_\_\_\_\_ **Office Rep (Signature)** \_\_\_\_\_

# Bourland~Soben and Partners Cosmetic & Family Dentistry

## Policy Regarding Insurance Assignment

Our office is pleased to accept your insurance. We offer this service as courtesy to our patients. However, it must be clearly understood that the **contract is between the patient and the insurance company**, the account hereby being the **responsibility of the patient for any amount not paid** by the insurance company. Following is a statement of our policies governing insurance claims:

1. Although our office does bill the insurance company, it is necessary for the patient to have all of the insurance information forms filled out completely. If this is not completed, we will not be able to appropriately bill the insurance company, and the responsibility for payment then becomes that of the patient. We are sorry, but there are **NO EXCEPTIONS** to this policy.
2. Our office will only bill your primary insurance company under any contractual limitations governing this process. We do not recognize or file to any secondary insurances.
3. We require our patients to sign an "Authorization to Pay the Doctor" form (or any other necessary documents required by your insurance company). By doing so, the insurance company will make payment directly to our office.
4. The patient will pay all co-payments and deductibles (the amounts not covered by the insurance company) as agreed upon during the financial consultation.
5. Insurance payments ordinarily are received within 30-60 days from the time of billing. If a patient's insurance company has not made payment to our office **within 60 days**, we will request the patient to pay the balance due. If and when the insurance company sends payment, the patient will be reimbursed.
6. Our office **does not guarantee** that the patient's insurance company will pay. We will perform our routine insurance billing procedures upon verification of coverage. However, if for some reason, the patient's insurance claim is denied, the patient is then considered to be responsible for the full amount of the bill.
7. Our office **will not enter into a dispute** with an insurance company over any claim; however, we will work with the insurance company to sort out any confusion or questions which might arise. We cooperate fully with the regulations and requests of the insurance companies. If any dispute arises over payment by the insurance company, it will be the **patient's responsibility to handle** this dispute.
8. If you have any complaints you may contact the Texas State Board of Dental Examiners, (TSBDE), at 333 Guadalupe, Tower 3, Suite 800, Austin, TX 78701-3942 or you can call TSBDE at 800-821-3205.

IF YOU UNDERSTAND AND AGREE WITH ALL OF THE ABOVE POLICES, PLEASE SIGN YOUR NAME BELOW AND WE WILL ACCEPT YOUR INSURANCE.

**Patient Name (Print):** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_ **Chart #:** \_\_\_\_\_

\_\_\_\_\_  
Legal Guardian Name (Please Print)

\_\_\_\_\_  
**Patient or Legal Guardian (Signature)**

**Today's Date:** \_\_\_\_\_