Bourland~Soben
AND PARTNERS
COSMETIC AND FAMILY DENTISTRY, P.L.L.C.

Health History

Chart#_____

Patient Name_____Date of Birth ____/____/_____SSN_____-_____-_____

Address _____City/State_____Zip_____
Address change for all family members? **YES**_____ **NO**_____

Cell _____ Home Phone _____Work Phone _____

Sex ☐ M ☐ F Marital Status ☐ Single ☐ Married 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 _____

MEDICAL INFORMATION Section 1

Yes	**No**	
☐	☐	Has there been any change in your general health within the past year?
		If yes, what condition is being treated? _____
☐	☐	Have you had a serious illness, operation, or been hospitalized in the past 5 years.
		If yes, what was the illness or problem? _____
☐	☐	Are you on any anticoagulants or blood thinners? If so, what type? _____

Yes	No	
☐	☐	Are you taking or have you recently taken any prescription of over-the-counter medicine(s)?

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

_____

☐	☐	Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax, Actonel, Atelvia Boniva, Reclast, Prolia) for osteoporosis or Paget's disease.
☐	☐	Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia, Zometa, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?

Date treatment began: _____

Date treatment ended: _____

HEART OR BLOOD DISORDERS Section 2

Yes	No		Yes	No	
☐	☐	Artificial (prosthetic) heart valve	☐	☐	Previous infective endocarditis
☐	☐	Damaged valves in transplanted heart	☐	☐	Congenital heart disease (CHD)
☐	☐	Unrepaired, cyanotic CHD	☐	☐	Repaired completely in last 6 months
☐	☐	Repaired CHD with residual defects	☐	☐	Cardiovascular disease
☐	☐	Angina (Chest Pain)	☐	☐	Heart attack
☐	☐	High blood pressure	☐	☐	Abnormal bleeding
☐	☐	Anemia	☐	☐	Stroke
☐	☐	Rheumatic Fever			

MEDICAL INFORMATION Section 3

Women Only: Are you:

Yes	No		Yes	No	
☐	☐	Pregnant	☐	☐	Taking birth control pills or hormonal replacement
		Number of weeks: _____	☐	☐	Nursing

All Patients

Yes	No		Yes	No	
☐	☐	Cancer/Chemotherapy/Radiation Treatment	☐	☐	Diabetes Type I ☐ Type II ☐
☐	☐	Eating disorder	☐	☐	Gastrointestinal disease
☐	☐	G.E. Reflux/persistent heartburn	☐	☐	Sleep disorder

Yes	No		Yes	No	
☐	☐	Do you snore?	☐	☐	HIV/AIDS
☐	☐	Hepatitis or liver disease	☐	☐	Sexually transmitted disease
☐	☐	Do you use tobacco	☐	☐	Do you clinch or grind your teeth
☐	☐	Do you suffer from chronic headaches	☐	☐	Do you use controlled substances (drugs)

☐ ☐ Have you had a joint replacement in the last two years?

☐ ☐ Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment?

☐ ☐ List any Allergies: _____

☐ ☐ Do you have any disease, condition, or problem not listed above that you think I should know about?

Please explain: _____

_____

What pharmacy do you prefer we send Rx's to? _____

In case of Emergency, Notify: _____ **Phone**: _____

Patient (or Legal Guardian) **Signature**: _____ **Date**: ____/____/_____

If Patient is a Minor: Legal Guardian Name (PRINT): _____

Relationship to Patient: _____

For Office Use Only: **Blood Pressure**:_____/_____

Assistant/Hygienist Name **(PRINT)**: _____

Doctor Name: ☐ Bart Bourland, DDS ☐ Wes Soben, DDS ☐ Johnathon Bogard, DDS

Doctor Signature_____ Date: ____/____/____

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:_____