



Spend less. Smile more.

DENTAL | ORTHODONTICS | EMERGENCY CARE

7am - 6pm, Monday - Friday and **EVERY** Saturday*

*“We are proud to be the first family-owned, multi-location practice in North Texas to offer **TOTAL PATIENT CARE** – family dentistry, cosmetic dentistry, orthodontics, dental implants, oral surgery, teeth whitening and toothache/emergency care – all under one roof!”*

~ Dr. John Bond, Founder

LOCATIONS:

Allen | Flower Mound | Roanoke

*not every location open every Saturday

Dr. John Bond,
Founder

1.888.SIX DAYS | 1.888.749.3297 | 6daydental.com



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Patient Information:

Patient's Name: Last First Middle Preference
Birthdate: Male/Female: Marital Status:
Social Security #: Driver's License #: State:
Address: Street Apt. # City State Zip
(Please provide all telephone numbers to contact you. There may be times when we need to reach you on short notice.)
Home: Work: ext Cell:
Email Address (optional): Other:

Insured's Name: Last First Middle Preference
Social Security #: Birthdate: Insured's Employer:
Insurance Co.: Group #: Insurance Phone #:
Insurance Address: Street Apt. # City State Zip

Spouse's Name: Birthdate: Social Security #:
Spouse's Employer: Spouse's Work Ph:
Is an immediate family member a patient here: Name:
How did you hear about us?

Responsible Party Information:

Self: Other: Last First Middle
If "Other," please complete: Relationship to Patient:
Birthdate: Social Security #: Driver's License #:
Address: Street Apt. # City State Zip
Home Ph: Work Ph:

Emergency Contact Information:

Name of nearest relative not living with you: Phone:
Address: Street Apt. # City State Zip

Broken Appointment Policy:

Reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving needed dental care in a timely fashion. So that the dentist, our staff, and our other patients will not be penalized by those who fail to keep scheduled appointments, our office policy stipulates that failure to give sufficient warning to keep a scheduled appointment, (24 hours advance notification), will result in a \$50.00 fee being charged. That charge which is in accordance with our dental office's broken appointment policy for all of our patients, is to be paid prior to the scheduling of any new appointment. The patient is responsible for payment of the charge.

Please feel free to discuss this and other policies with our staff.

Patient's Signature: Date:

Parent/Guardian signature if patient is a minor:



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- 1. Are you experiencing pain or discomfort? Y N
- 2. Are you in good health? Y N
- 3. Has there been a change in your general health within the past year? Y N
- 4. Are you under the care of a physician? Y N

If so, what condition is being treated? _____

Physician's Name: _____ Phone #: _____

Address: _____

- 5. Have you been hospitalized or had a serious operation or illness within the past 5 years? Y N
- 6. Do you have or have you had any of the following diseases or problems? Please circle:

| | | |
|----------------------------------|--------------------------|---------------------------------|
| AIDS/HIV Positive | Epilepsy/Seizures | Nervousness |
| Allergies or Hives | Fainting/Dizzy Spells | Pain in Jaw Joints |
| Anemia | Glaucoma | Plastics |
| Angina Pectoris | Hay Fever | Psychiatric Treatment |
| Arthritis | Heart Attack/Disease | Rheumatic Fever |
| Artificial Joint | Heart Failure | Rheumatism |
| Artificial Heart Valve | Heart Murmur | Scarlet Fever |
| Asthma | Heart Pacemaker | Sickle Cell Disease/Traits |
| Blood Transfusion | Heart Surgery | Sinus Trouble |
| Bruise Easily | Hepatitis A (Infectious) | Stroke |
| Chemotherapy (Cancer, Leukemia) | Hepatitis B (Serum) | STD or VD (Syphilis, Gonorrhea) |
| Cold Sores/Fever Blisters | High/Low Blood Pressure | Thyroid Disease |
| Congenital Heart Defects/Lesions | Kidney Trouble | Tuberculosis (TB) |
| Cortisone Medicine | Latex | Ulcers/Colitis |
| Cough | Liver Disease | Yellow Jaundice |
| Diabetes | Metals | X-Ray or Cobalt Treatment |
| Emphysema | Mitral Valve Prolapse | |

- 7. Are you taking any drug, medicine or herbal supplement? Y N

If so, what: _____

- 8. Are you allergic or have you reacted adversely to any drugs or medicines? Y N

If so, which drugs? _____

| | | | |
|---------|------------------|-----------------------|----------------|
| Aspirin | Erythromycin | lidocaine or Marcaine | Scopolamine |
| Codeine | Local Anesthetic | Penicillin | Sleeping Pills |
| Darvon | Nembutal/Seconal | Percodan | Tetracycline |
| Demoral | Nitrous Oxide | Other Antibiotics | Valium |

- 9. Have you had previous skin reactions to jewelry or know of an allergy to any metal? Y N
- 10. Have you had any serious trouble associated with any previous dental treatment? Y N
- 11. Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? Y N
- 12. Do you have a disease, condition, or problem not listed above that you think I should know? Y N

If yes, please explain: _____

- 13. **FOR WOMEN ONLY: ARE YOU PREGNANT?** Y N

If YES, what month? _____ Are you taking birth control pills? Y N

- 14. Is there anything about your smile you don't like such as discolored teeth, crooked teeth, unsightly silver fillings, etc.? Y N
- 15. Our doctors are accomplished cosmetic dentists. Would you like current information on smile improvement procedures they perform, such as bleaching, porcelain veneers, and tooth-colored restorations? Y N

CONSENT: The undersigned hereby authorizes Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with (Name of Patient) _____ and further authorize and consent that Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.

PATIENT _____ DATE _____ WITNESS _____

PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____



CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Social Security #: _____

Address: _____

Please list ALL telephone numbers where we can contact you: _____

Please list the names of ALL people (e.g. spouse, parents, etc.) you authorize us to release your health information to, including copies of your records if needed: _____

E-mail: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice, at any time by contacting:

The PRACTICE MANAGER at any of the following locations:

ALLEN
1205 W. McDermott Dr.
Allen, TX 75013
214.778.1900

COPPELL
120 S. Denton Tap Rd.
Suite 270-A
Coppell, TX 75019
972.393.7348

FLOWER MOUND
6050 Long Prairie Rd.
Suite 100
Flower Mound, TX 75028
972.316.6320

PLANO/FRISCO
8608 Preston Rd.
Suite 112
Plano, TX 75024
214.619.6329

ROANOKE/KELLER
200 E. State Highway 114
Roanoke, TX 76262
817.567.8040

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent.

SIGNATURE:

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

You are entitled to a copy of this consent after you sign it. Include completed consent in the patients chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You may refuse to sign this acknowledgement **

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

Please Print Name: _____

Signature: _____ Date: _____

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

I request and authorize Dr. _____ and 6 Day Dental & Orthodontics® to release my health care information to:

Name: _____

Address: _____

City, State, Zip: _____

Reason for requesting records: _____

This request and authorization applies to health care information relating to the following treatment, condition, or dates of treatment:

Or _____ All health care information Or _____ Other: _____

THIS AUTHORIZATION EXPIRES ON _____ OR _____ DAYS AFTER THE DATE IT IS SIGNED; or WHEN THE FOLLOWING EVENT OCCURS:

I may cancel this authorization to the extent allowed by law. If I do, I understand that the doctor or practice may have already released information about me after I gave permission. I know that canceling this authorization would not prohibit any release of information by the doctor or practice in reliance on my original authorization.

There are two ways to cancel this agreement. I can;

- Sign and date the bottom of this form under the section labeled "Revocation of Authorization"; or
- Write a letter to the doctor or practice. If I write a letter, it must say that I want to cancel my authorization to disclose my health care information. My letter must include the name or other specific identification of the person(s) that I no longer want to receive information. I (or my authorized representative) must sign and date the letter.

Once my doctor gives out the information that I want released, I know that my doctor has no control over the information. The individual or organization that I authorized to receive the information might re-disclose it. Federal or state privacy laws may no longer protect the information.

Signature of patient or patient's authorized representative

Date

Relationship or status if signed by parent, legal guardian, personal representative, etc.

REVOCAION OF AUTHORIZATION

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and health care operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it. Include completed consent in the patients chart.

ORTHODONTIC INFORMATION SHEET

Primary Orthodontic Insurance:

Insured's Name: _____
Last First Middle Preference

Social Security #: _____ Birthdate: _____ Insured's Employer: _____

Insurance Co.: _____ Group #: _____ Insurance Phone #: _____

Insurance Address: _____
Street Apt. # City State Zip

Adult:

What are the main concerns that you would like orthodontics to correct? _____

Have you ever had or been evaluated for orthodontic treatment before? Yes No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes No

Have you ever had an injury to your (please check): Face Mouth Teeth Chin

Do you have any missing or extra permanent teeth? Yes No

Have you ever had a serious/difficult problem associated with any previous dental work? Yes No

If yes, please explain: _____

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Do you have any speech problems? Yes No

If yes, please explain: _____

HAVE YOU HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? (Please circle Y or N individually)

| | | | |
|------------------------------|--------------------------|--------------------|-----------------|
| Y N Clenching/Grinding Teeth | Y N Lip Sucking/Biting | Y N Mouth Breather | Y N Nail Biting |
| Y N Speech Problems | Y N Thumb/Finger Sucking | Y N Tongue Thrust | |

Child:

What are the main concerns that you would like orthodontics to correct? _____

Has your child ever been evaluated for orthodontic treatment before? Yes No

Has your child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes No

Have there been any injuries to his/her (please check): Face Mouth Teeth Chin

Has your child been informed of any missing or extra permanent teeth? Yes No

Have adenoids or tonsils been removed? Yes No

Please list any musical instruments played: _____

HAS YOUR CHILD HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? (Please circle Y or N individually)

| | | | |
|------------------------------|--------------------------|--------------------|-----------------|
| Y N Clenching/Grinding Teeth | Y N Lip Sucking/Biting | Y N Mouth Breather | Y N Nail Biting |
| Y N Speech Problems | Y N Thumb/Finger Sucking | Y N Tongue Thrust | |

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform any necessary dental services my child may need. Initial _____

***** The Parent or Guardian who accompanies the child is responsible for payment. *****

If this office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible(s) that my insurance does not cover. Initial _____

Signature _____ Date _____

OFFICE USE ONLY: I verbally reviewed the medical/dental information above with the patient and patient named herein. Initials: _____ Date: _____