Welcome to your new dental home

RICHARDSON
COSMETIC DENTISTRY

Patient Information

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number	Date of Birth	Drivers License Number	Today's Date
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Emergency Contact Name	Relationship	Cell Number	Work Number

Person Responsible For Account ~ ☐Check Here If Same As Above

☐Mr. ☐Mrs. ☐Ms. ☐Dr. ☐Male ☐Female ☐Single ☐Married ☐Divorced ☐Widowed

First Name	Middle Name	Last Name	Preferred Name
Home Address	City	State	Zip
Social Security Number		Drivers License Number	Date of Birth
Home Phone	Cell Phone	Email	
Occupation	Employer Name	Employer Phone	
Emergency Contact Name	Relationship	Cell Number	Work Number

Dental Insurance Information

☐Check here if you do not have Dental Insurance ☐Check here if you previously provided information

Insured's First & Last Name	Date of Birth	Social Security
Name of Insured's Employer		Patient Relationship To Insured
Insurance Company	Phone	Subscriber ID #	Group ID #
Insurance Company Address	City	State	Zip

Referral Information

How did you first hear about our office?

☐Another Patient (relative or friend) - Their name _____

☐Another Dental or Medical Office ☐Work ☐ Social Media ☐Drove By Office ☐Google ☐Yelp ☐Church
☐Employee ☐Community/Charity Event ☐Insurance Company ☐Health/Benefits Fair or Event

Dental Health History

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Patient First Name | Patient Last Name | Date

CONDITIONS: Do you currently have, or have you had any history of the following?

- ☐ Sensitivity to: Hot, Cold, Sweet, Biting/Pressure, Touch
- ☐ Chipped or broken teeth
- ☐ Painful teeth. Where? _____
- ☐ Loose teeth, or worn down teeth
- ☐ Missing teeth, or spaces between teeth
- ☐ Catch food between teeth, difficulty flossing
- ☐ Dry mouth or constantly thirsty, painful swallowing
- ☐ Smoking or chewing tobacco products
- ☐ Bleeding, swollen or irritated gums
- ☐ Dissatisfied with appearance of my teeth
- ☐ Crooked, Shifting teeth, uneven/uncomfortable bite
- ☐ Jaw joint pain, difficulty opening wide, jaw locking, jaw dislocation, clicking or popping of the jaw
- ☐ Grinding or clenching teeth, frequent headaches
- ☐ Ulcers, lumps/bumps, areas of discoloration on head neck or in mouth
- ☐ Gag reflex

DENTAL WORK: Do you currently have, or have you had any of the following?

- ☐ Dentures or Partials/Flippers/Plate
- ☐ Braces or Clear Braces/Aligners
- ☐ Periodontal/Gum Disease or Gum Treatments
- ☐ Crowns or bridges
- ☐ Dental Implants
- ☐ Veneers, cosmetic bonding, whitening
- ☐ Night Guard
- ☐ Jaw Surgery
- ☐ Root Canals
- ☐ Retainer
- ☐ C-PAP Machine or Oral Sleep Appliance, Sleep Apnea
- ☐ Fear or Anxiety About Dental Treatment

GOALS: If I could enhance my smile, I would:

- ☐ Make My Teeth Whiter
- ☐ Make My Teeth Straighter
- ☐ Close Spaces or Gaps That Bother Me
- ☐ Replace Dark Metal Fillings With Tooth Colored Material
- ☐ Fix My Teeth So I'm Not Embarrassed When I Smile
- ☐ Repair Chipped Teeth
- ☐ Replace Missing Teeth
- ☐ Replace Old Crowns That Look Dark or Don't Match
- ☐ Have a Smile Makeover
- ☐ Stop My Jaw From Hurting or Clicking

On a scale of 1 – 10, with 10 being the highest rating:

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 do you want your dental health to be? 1 2 3 4 5 6 7 8 9 10

Let's get to know you!

Date of last cleaning? ___ / ___ Date of last oral cancer screening? ___ / ___ Date of last complete x-rays? ___ / ___

What is the **most important** thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

What is your end goal for your oral health/smile? _____

How can we help you get there? _____

What do you love to do in your spare time? _____

Medical Health History

RICHARDSON
COSMETIC DENTISTRY

(Please Print)

Patient First Name _____ Patient Last Name _____ Date _____

ASA _____

MEDICAL CONDITIONS: check any conditions you have currently or have had within past 5 years

- ☐ Anemia / blood disorder
- ☐ Easy bleeding or bruising
- ☐ HIV/AIDS
- ☐ Tuberculosis
- ☐ Asthma
- ☐ Emphysema/COPD
- ☐ COVID / Lung Disease
- ☐ Sleep Apnea/CPAP
- ☐ Shortness of breath
- ☐ Tobacco use / smoking
- ☐ Cancer ____
- ☐ Radiation (head/neck)
- ☐ Chemotherapy
- ☐ Infective endocarditis
- ☐ Chest pain
- ☐ Congenital heart defect
- ☐ Pacemaker, device, stent
- ☐ Heart failure / disease
- ☐ Heart valve replacement
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Heart attack / surgery < 5 yrs
- ☐ Mitral Valve Prolapse
- ☐ High Cholesterol
- ☐ Kidney disease
- ☐ Liver disease
- ☐ Diabetes. A1C _____
- ☐ Hepatitis A B C
- ☐ Thyroid disease
- ☐ Stomach issues, reflux, ulcers
- ☐ Stroke < 5 years
- ☐ Anxiety / Depression
- ☐ Head or neck injuries
- ☐ Dizziness / vertigo
- ☐ Seizures / fainting spells
- ☐ Mental illness / disability
- ☐ Drug or alcohol addiction
- ☐ Autoimmune disease
- ☐ Arthritis
- ☐ Osteoporosis
- ☐ Artificial joint (Hip or Knee Replacement)
- ☐ Jaw or sinus surgery

Women only

- ☐ Birth Control
- ☐ Nursing
- ☐ Pregnant: TM ____ _____ *Delivery Date*:

☐ Other/not listed _____

ALLERGIES: food, materials, or drugs?

- ☐ Aspirin
- ☐ Codeine
- ☐ Advil / Ibuprofen
- ☐ Azithromycin (Z-Pac)
- ☐ Latex
- ☐ Anesthetic
- ☐ Tylenol / Acetaminophen
- ☐ Plastic or metals
- ☐ Augmentin
- ☐ Penicillin / Amoxicillin
- ☐ Clindamycin
- ☐ Nuts _____

☐ List Other Allergies

_____

_____

_____

DRUGS: Please check any of the following drugs you have used at any time:

- ☐ Fosamax
- ☐ Boniva
- ☐ Actonel
- ☐ Other bisphosphonates
- ☐ Long term steroids
- ☐ Weight loss drugs

☐ Blood Thinners: Which one

_____

INR _____

MEDICATION LIST: list ALL medications you currently take AND what they are for (attach list if needed)

Drug > _____ _____ _____ _____

Purpose > _____ _____ _____ _____

Check if you get chest pain when:

__ Sitting and relaxing
__ Walking up 2 flights of stairs
__ Exercising
__ Never

Medical Appointments Information

Date of last check up with PCP: _____

Any surgery or hospitalizations past 5 years: Y N

Any care with specialists: Y N

Explain:

Under physicians care? Please explain?_____

_____

Physician's Name: _____

Physician's Phone: _____

I certify the information recorded on this medical & dental form is correct. I understand it is my responsibility to notify Richardson Cosmetic Dentistry of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Richardson Cosmetic Dentistry or its employees liable in the event of death or injury.

Signature (Patient / Guardian) _____ Date: _____ Dentist Signature: _____

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Financial, Insurance, and Appointment Policies

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality lifetime dental care, so that you may fully attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. **Payment is due at or before the time service is provided**. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available upon request and approval.

Please Note: Returned checks will be subject to additional fees. In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred.

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, **however it is not a guarantee that your insurance will pay exactly as estimated**. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- **All charges you incur are your responsibility regardless of your insurance coverage**. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- **We ask that you pay the deductible and co-payment,** which is the estimated amount not covered by your insurance company, by cash, check, MasterCard, Visa or Discover **at the time we provide the service to you.**
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure payment is expected. **If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.**
- We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. That includes providing all necessary documentation to expedite the payment of your dental claim. Each treatment recommended by your dentist is for your best interest and oral health. **However, not all insurance plans cover all treatment options. If your claim is still denied after multiple appeals, you will be responsible for paying the full amount of your treatment.**
- **Late Appointments**: Your time is important to us. In order to take care of you and other patients with the highest standards, we need your cooperation in coming to your appointment on time. **If you will be late, please call the office so we can plan accordingly. Rescheduling may be necessary.**
- **Cancellation Policy:** We require **at least 24 hours of notice** for cancellations. This is to accommodate other patients who are on the wait-list for your reserved appointment time. As a courtesy, we will allow a one time cancellation within 24 hours. After that, a **$25 cancellation fee will be due per late cancellation**. Extenuation circumstances will be considered on a case by case basis. All cancellation fees must be collected prior to scheduling your next visit.
- **Friday Reservations**: If you would like individualized attention, to get multiple treatments done at once, or would like oral sedation, we reserve convenient Friday appointments. On Fridays, we focus on one patient at a time. Since this entails reserving 2 or more hours just for you, we require a **10% reservation deposit at time of scheduling. If canceled without 24 hr notice, this deposit will not be refunded.**

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our financial policy.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND FINANCIAL POLICY. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Signature of Patient/Guardian Print Name Date

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Informed Consent For Notice of Privacy Practices

I understand that under the Health Insurance Portability & Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information may be used to:

- Conduct, plan, direct my treatment, and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly. My signature will also serve as a release should I request treatment or radiographs be sent to other attending Doctors in the future.
- Obtain payment from third-party payers in your behalf, ie... dental insurance.
- Conduct normal healthcare operations such as quality assessments and required local/federal 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 the right to review such *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 I may contact this organization at any time to obtain a current copy of the *Notice of Privacy Practices*.

I understand that according to Rule 108.8 of the Texas Administrative Code, I can request copies (not originals) of my dental records for $40 (includes x-rays).

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

I authorize Richardson Cosmetic Dentistry and its employees to contact me with information regarding my dental appointments, treatment, billing, health, and services.

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

Please list any other parties who can have access to your dental information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I have been informed & consent to these notices & release information to the above person(s)

_____
Patient Name

_____
Patient/Guardian Signature Date

PHOTO/MEDIA AUTHORIZATION

As a routine part of our practice, we take photographs and other images of patients and their teeth to diagnose, provide treatment and also for educational and promotional purposes. The Patient signing below ("you") hereby authorize Richardson General and Cosmetic Dentistry and its assigns (together, the "Practice") to: (a) take photographs, audio and/or video of you (individually and together, the "Images"); (b) publish the fact that the Practice provided dental services to you and any information or testimonials you provide regarding the Practice, treatment plan, diagnoses, city and state of residence, location of treating facility (collectively referred to herein as the "Information"); (c) reproduce, edit, use, and publish the Images and/or Information (together, "Work Product") with or without the Patient's name or attribution, in all forms and media, including but not limited to Internet sites and social media; and (d) obtain copyright registration for any publication that incorporates the Work Product. As consideration, you receive a license to use the Work Product and agree that no additional consideration or compensation will be provided for the Practice's use of the Work Product and hereby waives all claims to compensation and damages based on the Practice's use of such Work Product. The term of this Release is for 10 years from the date of the Patient's signature below (the "Term") and then perpetually renewing for 10 year terms unless it is earlier terminated. The Patient may terminate the Term, except to the extent that the Work Product has already been used or published by sending a written termination notice to the Practice. The Patient understands that any termination of the Term will not affect any action the Practice took in reliance on this authorization before receipt of the notice.

_____
Patient Name

_____ _____
Patient/Guardian Signature Date

Patient Consent for Text Messaging

Richardson General and Cosmetic Dentistry

Effective: 2025

We offer the convenience of communicating with you by text (SMS) messaging for purposes related to your care and account. This form explains how we use texting and asks for your consent to do so.

What You May Receive via Text:

- Appointment confirmations, reminders, or rescheduling
- Treatment plan or follow-up instructions
- Notifications about balances or insurance updates
- Occasional office updates, service notices, or patient satisfaction surveys

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Important Information:

- **Message Frequency:** Varies based on your care; generally no more than 5 messages/month
- **Carrier Charges:** Message and data rates may apply, depending on your mobile plan
- **Privacy Risks:** Texts are not encrypted. There is a small risk that messages could be intercepted or read by others (e.g., if your phone is unlocked)
- **Opt-Out:** You may opt out anytime by texting "STOP" to our number or calling the office
- **No Guarantee of Immediate Response:** Text messages may not be monitored 24/7. Do not use texting for urgent or emergency matters

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Consent and Authorization

By signing below:

- I authorize Richardson General and Cosmetic Dentistry to send me text messages related to my dental care, appointments, billing, or office updates.
- I understand that I can withdraw this consent at any time by texting "STOP" or notifying the office.
- I understand the risks of communicating via unencrypted text and agree to receive these messages anyway.

Patient Name: _____

Mobile Number: _____

Signature: _____

Date: _____