Welcome to our office! We appreciate the confidence you have placed with us to provide you with all your dental needs. In order for our office to give you the best dental care the information we are requesting is of the upmost importance and must be completed in its entirety. The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. If you have any questions please do not hesitate to ask. (Please fill this form out in its entirety do not leave blank spaces, if does not apply to you please list NA(Not Applicable) or UK(Unknown).

Patient Information

Patient Name:________________________________ Today's Date:______________________________

DOB:__________________ Sex:________ Age:________ SS #:________________________________

Home Address:____

City:_____________________________ State:_________ Zip:_____________

Home Phone:__________________ Cell:_________________ Work:__________________Ext:_________

Email:______________________________________ Drivers License #:_______________ State:______

Family Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer:____________________________ Occupation:__________________ How long there:_________

Person responsible for Account:_________________________ Relationship to Patient:____________________

Spouses Name:__________________________ DOB:___________________ Sex:_______ Age:_______

Spouses SS #:_____________________Cell:_____________________ Work:______________Ext:______

Other Family Members Seen by our office:____

In Case of Emergency Contact Information

Emergency Contact Name:______________________ Relationship to Patient:__________________________

Contact Phone #:___________________Cell/Work Address:______________________________________

2nd Emergency Contact Name:______________________ Relationship to Patient:_______________________

Contact Phone #:___________________Cell/Work Address:______________________________________

Whom may we thank for your referral to our practice? ☐ Patient ☐ Insurance ☐ Yellow Pages ☐ Drive By ☐ Internet

Referred By:____

Insurance / Financial Information

Thank you for selecting our office for your dental care. As your dental provider we are committed to the success of your treatment. Please understand that payment at the time of your treatment is considered a part of your commitment to our office. We ask that you carefully read the following and if you have any questions about our financial policies or your insurance please feel free to ask. **Payment is required at the time of treatment; we accept cash, checks, debit cards and all major credit cards. For extensive treatment, we do offer payment plans using a third party financing company with prior credit approval.**

Do you have Dental Insurance? ☐Yes ☐No Are you the Policy Holder? ☐Yes ☐No Is the Policy Holder? ☐Parent ☐Spouse

Policy Holder Name:____________________________ Policy Holder DOB:________________ Policy Holder SS:_______________

Policy Holder Employer:________________________________ Primary Insurance Company Name:___________________________

Insurance Phone #:_______________________ Insurance Address:____

Policy ID #:________________________________ Group #:_______________________________

Secondary Dental Insurance? ☐Yes ☐No Secondary Insurance Policy Holder Name:____

Policy Holder DOB:_______________ Policy Holder SS:___________________ Policy Holder Employer:_____________________

Secondary Insurance Company Name:_______________________________ Insurance Phone #:_______________________________

Insurance Address:____

Policy ID#:________________________________ Group #:________________________________

Insurance Terms & Conditions: Our office does accept all PPO insurance policies and as a courtesy to you as our patient we verify your most up to date coverage and file all and any insurance claims accordingly. If any information has changed with your insurance it is **your responsibility** to keep our office informed of any and all changes. Once a payment is received an account statement will be sent with the most up to date balance.

☐ I understand that dental services furnished to me and therefore are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that will be paid by an insurance company.

☐ I understand that "Reasonable and Customary" is a term used by insurance companies to reflect the agreement they have made with my **employer.** All disagreements with my insurance company will be my responsibility to resolve. As a courtesy to the patient this office will provide the insurance companies with all x-rays, narratives, and any requested information to help with the processing of any and all dental claims.

☐ I understand that the insurance **estimate** given to me for my dental treatment is just that an **estimate** until the dental claim has been processed by the insurance company and anything not covered or paid at that time **IS** my responsibility. I understand that I **must** request for a pre-determination be sent to my insurance for a more accurate **estimate** for dental treatment and even with a pre-determination this does not guarantee my insurance will pay said amount indicated on the pre-determination received from my insurance. (**Our office does not automatically send pre-determinations to your insurance company**). I also understand that this is an **estimate** and not a guarantee of payment.

If you are 18 years or older and you are currently still under your parents insurance and/or your parent is still financially responsible for your dental health you must give your consent to our office to share your personal dental health information with a personal representative (Parent, Step-Parent, Grandparent, Legal Guardian).

Parent Print Name: _________________________________ Date:___________________

Patient/Guardian Signature: ____

Ultimately as the insured ALL financials are your responsibility and any remaining balances on your account not paid by your insurance company is your responsibility.

Patient Print Name: _________________________________ Date:___________________

Patient/Guardian Signature: ____

HIPAA Notice of Privacy Practices

Marc R. Dandois DDS dental office originates and maintains paper records describing your health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. This information serves as a basis for planning your care and communication with other relevant health care providers. It is also a means by which a third-party can verify that conditions were present and services were provided competently. Your protected health information will be used by our practice or may be disclosed to others for the purposes of treatment, obtain payment by third party (e.g. your insurance company), or supporting the day-to-day- health care operations of this office.

You have the following rights and privileges:

- Notice of Privacy Practices: Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

- Use and Disclosure of your Protected Health Information: Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.
- Requesting a Restriction on the Use or Disclosure of Your Information: You may request a restriction on the use or disclosure of your Protected Health Information. Our office may or may not agree to restrict the use or disclosure of your Protected Health Information. If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.
- Revocation of Consent: You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

Dr. Marc Dandois has the following rights:

- To refuse treatment if the restrictions prevent Dr. Marc Dandois from providing adequate care and are not required agreeing to the restrictions requested.
- To change the terms of the Notice at any time and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of revised Notice of Privacy Practices from this office.

Formal Complaints: If you have any complaints about your privacy rights or how your health information has been used or disclosed, you may file a complaint with us by contacting our Privacy Officer. If you believe that the office of Dr. Marc Dandois has violated your privacy rights in any way you may file a complaint with the Texas Attorney General's Office.

Please contact our Privacy Officer for more information:

Jim Moore-Certified HIPAA Professional
1821 Golden Trail Court, Suite 220
Carrollton, TX 75010
Phone - (469)342-8300 Extension 508

Patient Print Name: ______________________________ Date:____________

Patient/Guardian Signature: ____

Medical History Questionnaire

Patient Name: ____ Birth Date: ____________________

We primarily treat the area in and around the mouth, ones mouth is a part of the entire body. Previous health problems and/or medication could have an important interrelationship with the dentistry the patient will receive. Please answer each of the following questions to the best of your knowledge. Thank You!

Does the patient have or has had, any of the following?

Condition		Condition		Condition		Condition	
Abnormal Bleeding	O Yes O No	Congenital Heart Disorder	O Yes O No	Heart Murmur	O Yes O No	Radiation Treatment	O Yes O No
ADD/ADHD	O Yes O No	Convulsion	O Yes O No	Heart Pacemaker	O Yes O No	Recent Weight Loss	O Yes O No
AIDS/HIV Positive	O Yes O No	COPD	O Yes O No	Heart Trouble/Disease	O Yes O No	Renal Dialysis	O Yes O No
Alcohol Addiction	O Yes O No	Cortisone Medicine	O Yes O No	Hemophilia	O Yes O No	Rheumatic Fever	O Yes O No
Anaphylaxis	O Yes O No	Crohn's/IBS	O Yes O No	Hepatitis A	O Yes O No	Rheumatism	O Yes O No
Anemia	O Yes O No	Diabetes I	O Yes O No	Hepatitis B or C	O Yes O No	Scarlet Fever	O Yes O No
Angina Pectoris	O Yes O No	Diabetes II	O Yes O No	Herpes	O Yes O No	Scoliosis	O Yes O No
Anxiety Disorder	O Yes O No	Down Syndrome	O Yes O No	High Blood Pressure	O Yes O No	Shingles	O Yes O No
Arthritis/Gout	O Yes O No	Drug Addiction	O Yes O No	High Cholesterol	O Yes O No	Sickle Cell Disease	O Yes O No
Arteriosclerosis	O Yes O No	Easily Winded	O Yes O No	Hiatal Hernia	O Yes O No	Sinus Trouble	O Yes O No
Artificial Heart Valve/Stents	O Yes O No	Emphysema	O Yes O No	Hives or Rash	O Yes O No	Special Needs/ Developmental Delay	O Yes O No
Artificial Joint	O Yes O No	Epilepsy or Seizures	O Yes O No	Hyperacidity	O Yes O No		
Asperger's Syndrome	O Yes O No	Excessive Thirst	O Yes O No	Hyperglycemia	O Yes O No	Spina Bifida	O Yes O No
Asthma	O Yes O No	Fainting Spells/Dizziness	O Yes O No	Irregular Heartbeat	O Yes O No	Stomach Intestinal Dis.	O Yes O No
Autism	O Yes O No	Fetal Alcohol Syndrome	O Yes O No	Kidney Problems	O Yes O No	Stroke	O Yes O No
Blood Disease	O Yes O No	Frequent Cough	O Yes O No	Leukemia	O Yes O No	Swelling of Limbs	O Yes O No
Blood Transfusion	O Yes O No	Frequent Diarrhea	O Yes O No	Liver Disease	O Yes O No	Thyroid Disease	O Yes O No
Breathing Problems	O Yes O No	Frequent Headaches	O Yes O No	Low Blood Pressure	O Yes O No	Tonsillitis	O Yes O No
Bruise Easily	O Yes O No	Frequent Nosebleeds	O Yes O No	Lung Disease	O Yes O No	Tuberculosis	O Yes O No
Cancer	O Yes O No	Genital Herpes	O Yes O No	Mitral Valve Prolapse	O Yes O No	Tumors or Growths	O Yes O No
Chemotherapy	O Yes O No	Glaucoma-Wide or Narrow	O Yes O No	Pain in Jaw Joints	O Yes O No	Ulcers	O Yes O No
Chest Pains	O Yes O No	Hay Fever	O Yes O No	Parathyroid Disease	O Yes O No	Venereal Disease	O Yes O No
Cold Sores/Fever Blister	O Yes O No	Heart Attack/Failure	O Yes O No	Psychiatric Care	O Yes O No	Yellow Jaundice	O Yes O No

Are you allergic or have you ever had an allergic reaction to any of the following?

Allergen		Allergen		Allergen		Allergen	
Penicillin/Other Antibiotics	O Yes O No	Sulfa Drugs	O Yes O No	Latex or Rubber Dam	O Yes O No	Codeine/Demerol	O Yes O No
Aspirin	O Yes O No	Metals	O Yes O No	Barbiturates/Sedatives	O Yes O No	Other Narcotics	O Yes O No
Acetaminophen	O Yes O No	Ibuprofen	O Yes O No	Sleeping Pills	O Yes O No	BENADRYL	O Yes O No

Other allergy not listed above ____

Women: Are you any of the following?

Pregnant/Trying	O Yes O No	Nursing	O Yes O No	Taking Birth Control	O Yes O No	Menopause	O Yes O No

Do you have or have you had any disease, condition, or problem not listed above? O Yes O No

If yes, please list: ____

Are you currently under a physician's or a specialist's care? O Yes O No

If yes, please list why: ____

Primary Care Physician Name: ______________ **Phone Number:** ______________ **Last Medical Examination:** __________ **Last Physical** __________

Physician's Name ______________ Specialty: ______________ Phone: ______________

Physician's Name ______________ Specialty: ______________ Phone: ______________

Physician's Name ______________ Specialty: ______________ Phone: ______________

Has your physician or any other doctor told you that you require antibiotics (pre-med) prior to dental treatment due to Heart Murmur, Rheumatic Fever, Joint Replacement, Artificial Joint, or Organ Transplant? O Yes O No

If yes, please list: ____

Pharmacy Name: ______________________ **Phone Number:** ______________________

Have you ever taken medications for weight loss (diet pills)? (i.e. O Fen-Phen O Pondimin O Redux O Other) O Yes O No

If yes, did you have a medical exam for heart issues?: ____

Are you presently taking medication or drugs? If yes, please list Name and Dosage: O Yes O No

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Medication Name:______________________ Dosage:______________________

Have you been hospitalized for any reason within the past 5 years? O Yes O No

If yes, please list why:______________________

Have you ever had and minor or major surgeries? If yes, please list below: O Yes O No

Type of Surgery:______________________ Year Surgery Done:______________________

Type of Surgery:______________________ Year Surgery Done:______________________

Type of Surgery:______________________ Year Surgery Done:______________________

Have you ever had a serious head or neck injury? O Yes O No

If yes, please explain:______________________

Are you on a special diet? O Yes O No

If yes, please list why:______________________

Do you smoke, chew tobacco, or use E-Cigarettes? O Yes O No

If yes, please indicate which one(s), daily frequency, and how long?______________________

____

Family History of Surgeries(Please list all Major and Minor Surgeries and relation to you; e.g. Mother, Father, Grandparent, not Necessary to list aunts/uncles etc.______________________

____

____

Family Medical History(Please list all Medical History and relation to you; e.g. Mother, Father, Grandparent, not necessary to list aunts/uncles etc..)):______________________

____

____

This practice of dentistry involves treating the whole person, if the dentist determines that there may be a potential medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorized the dentist to contact my physician for further information needed to continue with my care. I have read and understand this form, and to the best of my knowledge, I have answered every question completely and accurately. I understand that ultimately it is my responsibility to inform my dentist of any change in my health and /or medications. I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Print Name: ______________________ Date:__________

Patient/Guardian Signature: ______________________

I have reviewed my medical history and confirm that it states past and present medical conditions ______________ Signature ________ Date

I have reviewed my medical history and confirm that it states past and present medical conditions ______________ Signature ________ Date

I have reviewed my medical history and confirm that it states past and present medical conditions ______________ Signature ________ Date

I have reviewed my medical history and confirm that it states past and present medical conditions ______________ Signature ________ Date

Dental Health History

How we perceive our smile and appearance affects our self-esteem, our moods and how we function in social and business relationships. As your dental provider our goal is to give you a better feeling, more beautiful smile that can have a powerful impact on your lifestyle and comfort level. This line of questioning is based strictly on your own inner feelings and whether or not your smile perception projects character and confidence or projects a poor self-image and/or makes you feel uncomfortable.

Please tell us what brought you to our office today? ____________________

Previous Dentist Name:____________________ Phone Number:____________________

Address:____________________

Last Dental Visit:__________ Last Dental Cleaning:__________ Last Dental X-rays:__________ O Full Mouth Series O Bitewings O Panoramic

What has kept you from seeing a dentist on a regular basis? ☐ Money ☐ Condition of teeth ☐ Apprehension ☐ Other

Please explain: ____________________

Are you interested in sedation dentistry? O Yes O No

If yes, Why?____________________

Are you allergic or have had an allergic reaction to dental anesthetic?(i.e. Novocain, Nitrous, Numbing Gel, etc..) O Yes O No

If yes, please explain:____________________

Do you have difficulty with Dental Anesthesia? O Yes O No

If yes, please explain:____________________

Have you had problems with previous dental treatment? O Yes O No

If yes, please explain:____________________

Have you ever been told you need or have you ever had a deep cleaning? O Yes O No

If yes, Date of last deep cleaning?____________________

How often do you brush? ____________________

- Do you take fluoride supplements?.......O Yes O No
- Do you gag easily?.......O Yes O No
- Do you wear dentures?.......O Yes O No
- Does food catch between your teeth?.......O Yes O No
- Do you have difficulty in chewing your food?.......O Yes O No
- Do you chew on only one side of your mouth?.......O Yes O No
- Do you avoid brushing any part of your mouth because of pain?.......O Yes O No
- Do your gums bleed?.......O Yes O No
- Do your gums bleed when you floss?.......O Yes O No
- Do your gums feel swollen or tender?.......O Yes O No
- Have you ever noticed slow-healing sores in or around your mouth?.......O Yes O No
- Are you unable to open your mouth as far as you want?.......O Yes O No
- Have you ever worn a bite plate or mouth guard?.......O Yes O No

- Are your teeth sensitive?.......O Yes O No
- Do you feel twinges of pain when your teeth come in contact with:
  - Hot foods or liquids?.......O Yes O No
  - Cold foods or liquids?.......O Yes O No
  - Sweets?.......O Yes O No
  - Sours?.......O Yes O No

How often do you floss? ____________________

- Do you clench or grind your jaws frequently?.......O Yes O No
- Does your jaw make noise so much that it bothers you or others?.......O Yes O No
- Do your jaws ever feel tired?.......O Yes O No
- Does it hurt when you chew or open wide to take a bite?.......O Yes O No
- Do you have symptoms or headaches upon awaking in the morning?.......O Yes O No
- Do you find jaw pain or discomfort extremely frustrating or depressing?.......O Yes O No
- Have you had an injury to head/jaw (trauma)?.......O Yes O No
- Do you have tempromandibular (jaw) disorder? (TMD).......O Yes O No
- Do you have pain in the face, cheeks, jaws, joints, throat, or temples?.......O Yes O No
- Are you a habitual gum chewer or pipe smoker?.......O Yes O No
- Are you aware of an uncomfortable bite?.......O Yes O No
- Have you ever had your bite adjusted by a dentist?.......O Yes O No
- have you ever had any surgery done to your mouth?.......O Yes O No
- Do your prefer to save your teeth?.......O Yes O No
- Jaw pain or discomfort affects your appetite, sleep, daily routine, other activities?.......O Yes O No
- Have you ever had orthodontic treatment?.......O Yes O No
- If yes, when?____________________
- Do you currently or have ever had Sleep Apnea?.......O Yes O No
- If yes, do you use a sleep apnea machine? Snore guard?

- Are you unhappy with the appearance of your smile?.......O Yes O No
- Do you have existing crowns that you are unhappy with the way they look?.......O Yes O No
- Do you have dark (silver) fillings that you are unhappy with?.......O Yes O No
- Are you unhappy with the way your gums look?.......O Yes O No
- Do you have spaces or gaps in your smile that make you unhappy?.......O Yes O No
- Are you unhappy with the crowded or out of line teeth in your smile?.......O Yes O No
- Do the stains or discoloration of your teeth bother you?.......O Yes O No
- Do you have visibly missing teeth that make it uncomfortable to smile all the way?.......O Yes O No

If you could change anything with your smile what would that be?____________________

And Why? ____________________