South Austin Family Dental

David W. Euers, DDS **135 W. Slaughter Ln Austin, TX 78748**
Shelby L. Knight, DDS **512-280-1117**

Name ____ Preferred Name ____________________

Name of spouse or parent ____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Other Sex: ☐ Male ☐ Female

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired Student Status: ☐ Full Time ☐ Part Time

Home phone #_______________ Work phone #___________________ Cell phone #_______________

SSN #____________________________ TXDL# _________________ Date of Birth _________________

Home Address ____________________________ City _____________ State _______Zip ___________

Patient employer ___________________________ Who will pay this account? ______________________

Referred by _______________________ Emergency contact ___________________ phone ___________

DENTAL INSURANCE

Insurance Co. _____________________________ Phone ____________ Group # ________ Employer _______________

Subscriber's name ____________________________ DOB __________________ SSN ____________________________

Address(if different than patient's) _________________________________ Relation to patient _______________________

DENTAL/MEDICAL HISTORY

When was your last dental visit? ___________________________ Last checkup with X-rays? _______________________

Are you having any discomfort? YES / NO. If yes, please describe ____

Medical Doctor's name ____ Office phone #_______________________

Preferred Pharmacy and Phone # ____

Have you ever taken medication for Osteoporosis? YES/NO If yes, Oral or IV?________ for how long?___________

Are you under a physician's care now? YES/NO. If yes, please explain_____________________________________

Have you ever been hospitalized or had a major operation? YES/NO. If yes, please explain______________________

Have you ever had a serious head or neck injury? YES/NO. If yes, please explain_______________________________

Are you taking any medications? YES/NO. If yes, please explain___________________________________

Are you on a special diet? YES/NO. If yes, please explain____

Do you use tobacco? YES/NO. If yes, how much a day? __________________ For how long? ____________________

Do you use controlled substances? YES/NO

Have you ever had excessive bleeding that required special treatment? YES/NO. _______________________________

Women: Are you pregnant/ Trying to get pregnant? YES/NO If yes, how many months? _______________________

Taking oral contraceptives? YES/NO Nursing? YES/NO

PLEASE CIRCLE ANY OF THE FOLLOWING YOU ARE ALLERGIC TO:

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Sulfa

Other ____

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING:

Aids/HIV Positive	YES / NO	Epilepsy or Seizures	YES / NO	Lung Disease	YES / NO
Anaphylaxis	YES / NO	Excessive Thirst	YES / NO	Pain in Jaw Joints	YES / NO
Artificial Heart Valve	YES / NO	Fainting Spells/ Dizziness	YES / NO	Radiation Treatments	YES / NO
Artificial Joint	YES / NO	Heart Pace Maker	YES / NO	Sinus Trouble	YES / NO
Asthma	YES / NO	Heart Trouble/Disease	YES / NO	Stroke	YES / NO
Bruise Easily	YES / NO	Hepatitis A or B or C	YES / NO	Thyroid Disease	YES / NO
Chest Pains	YES / NO	High Blood Pressure	YES / NO	Tonsillitis	YES / NO
Cold Sores/Fever Blisters	YES / NO	Hives or Rash	YES / NO	Tuberculosis	YES / NO
Congenital Heart Disorder	YES / NO	Kidney Problems	YES / NO	Tumors or Growth/Cancer	YES / NO
Diabetes	YES / NO	Liver Problems	YES / NO	Ulcers/Canker Sores	YES / NO
Easily Winded	YES / NO	Low Blood Pressure	YES / NO		

If you answered YES to any of the above or have any other health problems please explain:

____

Should any changes in my medical history occur that would effect my treatment here, I agree to report this to you.

I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental insurance carrier or payer of my dental benefits may pay less than my actual bill of services. I understand I am financially responsible for payments in full of all accounts. By signing this statement I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.

PLEASE BE ADVISED THAT IT IS OUR OFFICE POLICY THAT ALL SERVICES RENDERED SHALL BE PAID ON THE DAY OF SERVICE UNLESS PREVIOUS ARRANGEMENTS HAVE BEEN MADE.

SIGNED: ____ DATE ________________________

Dr. Signature ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have read a copy of this office's Notice of Privacy Practices which is posted in the waiting room.

____
(Please Print Name)

____
(Signature)

____
(Date)

DAVID W. EUERS, DDS
SHELBY L. KNIGHT, DDS
135 W. SLAUGHTER LANE
AUSTIN, TX 78748
512-280-1117

Important Information About Dental Insurance!!!!!

- **As a courtesy to our patients we are happy to assist you in filing dental claims**. Our staff is experienced in dealing with insurance companies.
- Our office is **NOT** a party to contracts with any insurance companies. Your benefits are selected and administered by **YOU, YOUR EMPLOYER,** and **THE INSURANCE COMPANY**.
- We will provide the best **ESTIMATE** possible for your treatment based on information offered from your insurance company.
- There is **NO GUARANTEE** that your insurance company will pay the full percentage of any procedure. Some procedures are not covered at all.
- Insurance companies use specific fees as guidelines to determine payment. In MOST CASES those fees are not the same as our office fee, therefore, you are responsible for any unpaid balance.
- Payment for procedures not covered is expected no longer than 30 days after insurance payment is received in our office.
- Your insurance company may use "alternate benefits" to determine payment to our office. This means the company may pay based on a procedure of a lesser charge making you responsible for the difference.

By signing below, you agree to abide by office policy regarding your dental insurance.

_______________________________ _______________________

Patient Signature Date