South Austin FAMILY DENTAL
Shelby L. Knight, DDS & Miranda E. Torrey, DDS

135 W. Slaughter Ln. Ste. C
Austin, TX 78748

Name_____Preferred Name _____

Name of spouse or parent: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered - Sex: ☐ Male ☐ Female ☐ Intersex

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_____

Email _____

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 checked 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 list medication and dosage:

_____

_____

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 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 affect 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 _____

NOTICE OF HEALTH INFORMATION PRACTICES ACKOWLEDGEMENT FORM

The attached notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please sign this cover sheet acknowledging receipt of the policy and return it to the receptionist. Review the policy careful and let us know if you have any questions or requests.

By my signature below, I acknowledge that I have received the Notice of Health Information Practices of South Austin Family Dental. I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions requested. I understand that may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

Name of Patient:

_____

Signature of Patient: Date:

_____ _____

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 you 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 later 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.
- Patients having dual insurances will still be responsible for payment at time of service, until we are aware of how the secondary will pay out. Any over payment on the patients' behalf will be reimbursed to the patient.

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

Signature of Patient: _____ Date: _____

LOCAL ANESTHESIA CONSENT FORM

Although the use of local anesthetics to control pain is a safe, well-established procedure, adverse reactions can occur. These reactions include, but are not limited to the following:

1. **Fainting (vasodepressor syncope)** with or without a rapid pulse and lowered blood pressure. Usually associated with fear.

2. **Rapid heartbeat (short term)** can occur during the administration of local anesthesia. This is due to the epinephrine that is included in most anesthetics. Everybody has epinephrine in their body naturally, it is often referred to as adrenaline. However, it can make your heart feel like it is racing for a few minutes when the medication is first introduced into your body. If you already have high blood pressure, let the dentist know and an anesthetic can be used without epinephrine.

3. **Hyperventilation syndrome** is usually brought on by fear. It is characterized by tingling in the hands, lightheadedness and tightness in the chest.

4. **Toxicity reactions** initially appear as dizziness. blurred vision, or tremors and can proceed into drowsiness, convulsions, unconsciousness, or even respiratory or cardiac arrest. Toxicity reactions occur from an overdose or rapid absorption of the anesthetic into the bloodstream. Although we will never use more anesthetic than recommended for your body size, it is important to realize everybody has their own tolerance level. pleases advise the doctor if you are more, or less, tolerant of medications in general.

5. **Allergic reactions** to today's local anesthetics (lidocaine/septocaine/carbocaine) are extremely rare. Allergic reactions are characterized by cutaneous lesions, edema/swelling, redness and other manifestations of allergies. Anaphylactic reactions involving trouble breathing, rarely happen, but will require us to call 911 if they do occur to ensure your safety.

6. **Idiosyncratic reactions** of unexplained origin are exaggerated responses to an average dose of a drug. these reactions present clinically in a wide range of manifestations. Please inform the doctor if you have a history of severe reactions to medical treatment.

There are also several complications that can arise from the injection itself that you should be aware of:

1. **Numbness** to additional areas of the face can occur due to variations in nerve anatomy. For example when we anesthetize the lower teeth the nerve branches carry anesthetic to the lower lip and tongue as well the teeth. Sometimes the anesthetic may be carried along other nerve branches as well, in turn numbing other areas of the face. Other common areas to receive anesthesia are the temples. eyelids, cheeks and chin. Often, when the eyelids

are anesthetized, the effected eye cannot close and will tear up. These areas will start to feel and react normally once the anesthesia wears off. Anesthesia typically lasts between 1 and 4 hours but varies for each individual.

2. **Paresthesia** may occur if the nerve trunk is traumatized by the needle during the injection of anesthesia. This results in a residual thingling sensation, of in partial numbness of the affected tissue. Although paresthesia following a lower injection usually presents as a residual tingle in the lower lip and tongue, it can also affect the eyelids. cheeks and chin. The symptoms of paresthesia gradually diminish, and recovery is usually complete. It is important that you inform the dentist as soon as you experience symptoms of parenthesia so that you can undergo treatment right away if needed. Early treatment is essential for success in certain cases of paresthesia.

3. **A quick feeling of "shock"** can occur as the anesthetic is administered near the nerve. Often described as a feeling of electrical shock. This is normal and has no long term effects.

4. **Hematoma (swelling with bruising)** can occur when a blood vessel is punctured during the injection. The released blood will pool under the influence of gravity and form a hematoma. Bruising may be visible for up to 2 weeks.

5. **Trauma to lips and cheeks** is a common complication of dental work. Largely because when you are numb you will not feel a bite injury as it occurs. Therefore we recommend that you do not eat when you are numb. Also your lips may become dry, chapped, and cracked as a result of your procedure today.

6. **Reoccurrence of cold sores**. This can only happen to those individuals who already carry the virus for cold sores. In between outbreaks, the Herpes virus that causes cold sores lies dormant within your nerves. Therefore when the nerve is anesthetized, the virus may be trigged/awakened to form a new cold sore. Prescription medication can be taken prior to treatment to avoid a new outbreak.

7. **Jaw pain** often occurs for 2 reasons. One reason being the muscles around the jaw may be traumatized by the injection of anesthesia. Another reason is muscle fatigue that results from holding your mouth in an open position for an extended time period.

This consent is good for all future treatment requiring Local Anesthesia

Patient or Guardian: Date: Witness: Date:

_____ _____ _____ _____