



Ingram Hills Dental  
Michele M. Bishop, D.D.S.

Patient's Name \_\_\_\_\_ Gender \_\_\_\_\_ Martial Status \_\_\_\_\_  
Date of Birth \_\_\_\_\_ SS# \_\_\_\_\_ Driver's License # \_\_\_\_\_  
Address \_\_\_\_\_ Apt # \_\_\_\_\_ City/St/Zip \_\_\_\_\_  
Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_  
E-Mail Address \_\_\_\_\_  
Employer \_\_\_\_\_ Occupation \_\_\_\_\_  
How did you hear about us? \_\_\_\_\_

**Person to contact in case of an emergency:**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

**Insurance: We file all necessary forms & reports to your insurance company. We do NOT render our services on the basis the insurance company pays our fees. The patient/patient's guardian is personally responsible for any fee the insurance company does not cover.**

Insurance Subscriber Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
SS# \_\_\_\_\_ Member ID # \_\_\_\_\_ Employer \_\_\_\_\_  
Group # \_\_\_\_\_ Phone # \_\_\_\_\_  
Secondary Insurance \_\_\_\_\_ Group # \_\_\_\_\_  
Member ID # \_\_\_\_\_ Phone # \_\_\_\_\_

**PLEASE READ AND INITIAL EACH ONE:**

\_\_\_\_\_ **CANCELLATION POLICY:** 24 hour notice in advance is required for any cancellation of a dental appointment

\_\_\_\_\_ **PAYMENT POLICY:** Payment must be made at the time services are rendered unless prior arrangements are made. I understand I am ultimately responsible for the balance on my account. If I fail to meet the requirements, I know this matter will be turned over to an outside collection agency and legal charges may be filed against me.

\_\_\_\_\_ **CONSENT TO TREATMENT:** I authorize Dr. Bishop and her staff to perform procedures including but not limited to prophylaxis (cleanings), x-rays and photographs, administering anesthetics and/or medications, restoring (filling) teeth, endodontics (root canal) therapy and other procedures she may deem necessary for my/my child's dental care.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

### Dental History

When was your last dental treatment? \_\_\_\_\_ Last cleaning \_\_\_\_\_ X-rays \_\_\_\_\_  
Have you had a bad dental experience? Explain \_\_\_\_\_ Yes/No  
Have you ever had periodontal treatment (Gum Disease)? Yes/No Do you gums Bleed? Yes/No  
Are any of your teeth loose? Yes/No Does food catch in between your teeth? \_\_\_\_\_ Yes/No  
Do you have difficulty in opening/closing your mouth? \_\_\_\_\_ Yes/No  
How often do you brush your teeth? \_\_\_\_\_ Do you floss? \_\_\_\_\_ How often? \_\_\_\_\_  
Have you noticed any lumps, growths or swelling in your mouth? \_\_\_\_\_  
Do you/ have you ever smoked, chewed? Yes/No How much do you smoke? \_\_\_\_\_

### Medical History

Are you under the care of a physician? \_\_\_\_\_ Yes/No  
Physician Name \_\_\_\_\_ Phone \_\_\_\_\_  
Have you ever had a Joint replacement? Yes/No Where? \_\_\_\_\_ When? \_\_\_\_\_  
Are you taking or have taken an antiresorptive agent for Osteoporosis or Paget's disease? Yes/No  
Are you taking any medications? Yes/No List: \_\_\_\_\_  
Are you allergic to any medications? Yes/No List: \_\_\_\_\_

#### **Please circle all that pertain to you:**

Angina/Chest Pain	Cortisone Medicine	Hepatitis Type	Recent Weight Loss
Aids	Diabetes	High Blood Pressure	Renal Disease
Allergies	Drug Addiction	HIV +	Rheumatic Fever
Alzheimer's Disease	Emphysema	Hive/Rash	Shortness of Breath
Anemia	Epilepsy or Seizures	Hypoglycemia	Sickle Cell Disease
Arthritis/ Gout	Fainting/Dizziness	Irregular Heart Beat	Sinus Trouble
Artificial Heart Valve	Frequent Cough	Kidney Problems	Stomach/Intestinal Issues
Asthma	Frequent Diarrhea	Leukemia	Stroke
Blood Disorder	Frequent Thirst	Liver Disease	Swelling of Limbs
Blood Transfusion	Genital Herpes	Low Blood Pressure	Taking Aspirin
Breathing Problems	Glaucoma	Lung Disease	Taking Blood Pressure
Bruise Easily	Hay Fever	Mitral Valve Prolapse	Tumors/ Growths
Cancer	Heart Attack/ Failure	Nervousness	Ulcers
Chemotherapy	Heart Murmur	Pain in Jaw	Use of Recreational Drugs
Congenital Heart Disorders	Heart Pace Maker	Parathyroid Disease	Veneral Disease
Cold Sores/ Fever Blisters	Heart Surgery	Psychiatric Care	Yellow Jaundice
Convulsions	Heart Trouble	Radiation Treatment	

Pharmacy Phone#/Location \_\_\_\_\_  
Women (Please Check) ( ) Pregnant ( ) Trying to get Pregnant ( ) Nursing ( ) Taking Oral Contraceptives

*To the best of my knowledge all the above answers are correct. If any of the information changes I will inform the dentist at my next visit.*

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed By Doctor: \_\_\_\_\_ Date: \_\_\_\_\_



**Payment is due** at the time services are rendered. For your convenience we accept cash, credit cards, personal check or money order.

**Insurance** benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies will not pay for all your costs. Your insurance policy is a contract between you and your insurer. Your insurance and payment are still your responsibility. As a courtesy we will be glad to file your claim for you if you bring 1) your dental insurance card and 2) all required employer information. You will be expected to pay for services rendered if the office is unable to verify your insurance information before treatment or if the insurance company denies or downgrades payments after services are rendered. If payment for services already rendered has not been paid in full within 45 days, either by you or your insurance company, the remaining balance for treatment is considered due and collectible from you. We reserve the right to turn accounts over 90 days over to a collection agency.

We reserve the right to charge and collect fees for broken appointments – appointments that are cancelled or broken without 24 hours' notice. Appointments are reserved exclusively for you.

**Returned Check Fee** of \$30 will be added to your account balance and is collectible if your personal check is returned for insufficient funds by your bank.

Cash and Senior courtesies cannot be applied to insurance copayments and are not applicable to credit card payments. Courtesies cannot be combined and are not to exceed 5%.

I have read and understand this financial policy.

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Signature

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Date

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Printed Name

**INGRAM HILLS DENTAL, PLLC.**  
4496 Callaghan Road, San Antonio, Texas 78228

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

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

I, \_\_\_\_\_, acknowledge that I have reviewed this office's  
Notice of Privacy Practices. I understand that a copy of this Notice will be made available  
to me at my request.

\_\_\_\_\_  
(Please Print Name)

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

**Authorization to Use or Disclose My Health Information**

The following information is required by law, giving your consent to disclosure of  
information regarding any aspect of your treatment in our office to any person other than  
the patient.

I, \_\_\_\_\_, authorize the release of my Personal  
Health Information information to:

(Name)

(Relationship)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For Office Use Only

**DOCUMENTATION OF GOOD FAITH EFFORTS**

On this date, the patient was treated and was given a copy of the Notice of Privacy Practices. An  
attempt was made to obtain a written acknowledgement of receipt of the Notice; however, an  
acknowledgement was not obtained because:

Patient refused to sign.

Communications barriers prohibited obtaining the acknowledgement

Patient was unable to sign due to: \_\_\_\_\_

Signature of employee completing form: \_\_\_\_\_