JASON D. ROE, DDS, FACP

Patient Information

Patient Name: _____ **Preferred Name:** _____
LAST FIRST M

Date of Birth_____ **Social Security #:**_____ **DL/ID #:**_____

☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other** **Gender** ☐ **Male** ☐ **Female** **Weight:** _____ **Height:** _____

Phone (HOME): _____ **(WORK):** _____ **(CELL):** _____

Address: _____ **EMAIL:**_____
CITY STATE ZIP CODE

MEDICAL HISTORY: Have you ever had any of the following? Please check those that apply:

- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Aspirin Allergy
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Diabetes: Type
- ☐ Dizziness
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis _____
- ☐ High Blood Pressure
- ☐ HIV / AIDS
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Mitral Valve Prolapse
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Seasonal Allergies
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Taking Aspirin Daily
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OSTEOPOROSIS Medication? ☐ Yes ☐ No (EX:Fosamax/Actonel/ Boniva/Aredia/Zometa)

For Women ONLY: Are you taking birth control? ☐ Yes ☐ No
Are you pregnant? ☐ Yes ☐ No

- **Are you allergic to any medication? Have you ever had an allergic reaction to a medication? If yes, describe:** _____
- **Are you taking any medications at this time? If yes,** please list on Medication Information Form.
- Have you ever had to pre-medicate with antibiotics for dental treatments? ☐ Yes ☐ No
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
- If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
- If yes, please explain: _____
- Previous Surgeries: _____
- Are you now under the care of a physician? ☐ Yes ☐ No If yes, please explain: _____
- Name of Physician: _____ Phone #: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
- If yes, please explain: _____
- **Do you use tobacco? ☐ Yes ☐ No If yes, what and How often?** _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health; I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian: _____ **Date:** _____

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Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Home Phone: _____ Work Phone: _____ Ext: _____

Address: _____

Street Apartment #

_____

City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ **Insured's Birth Date**: _____

Phone # of Insured: _____ **Insured's Social Security** #: _____ **Relationship to patient**:_____

Insured's Address:_____

Insured's Employer:_____

Insurance Plan Name and Address:_____

_____

Insurance Phone #: _____ **Insurance Group #:** _____

Secondary

Name of Insured: _____ Insured's Birth Date: _____

Phone# of Insured: _____ Insured's Social Security #: _____ Relationship to Patient: _____

Insured's Address: _____

Insured's Employer and Address: _____

Insurance Plan Name and Address: _____

_____

Insurance Phone #: _____ Insurance Group#: _____

JASON D. ROE, DDS, FACP

Consent For Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. All emergency dental services must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will file the claims to the insurance companies and help with phone calls to them when necessary. All quotes given from insurance companies are just estimates and are NEVER a guarantee of payment. This office will send pre-estimates to the insurance companies if requested by patient. Patient's estimated co-pay will be due at the date of service unless other arrangements have been made. Any claim not paid within 45 days of the date of service will then be the patient's responsibility. The balance not paid by the insurance will be due by the patient.

----I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

----I grant my permission to you or you assignee, to telephone me at home or at my work to discuss matters related to this form.

----I understand that I am completely responsible for the payment of all expenses incurred. I assign and authorize Jason D. Roe, DDS, PLLC payment of any and all benefits payable by Insurance and the necessary release of medical information needed to process all insurance claims. In the event of non-payment I agree to bear the cost of collection and/or court costs and reasonable legal fees not to exceed 50% of the unpaid balance. The undersigned waives rights of exemption under the state of Texas. Payment is required at the time of Service!

I hereby authorize any treatment deemed necessary by Jason D Roe, DDS, FACP

_____ _____

(Patient Signature/ Responsible Party) (Date)

JASON D. ROE, DDS, FACP

REGISTRATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

I also authorize Dr. Jason Roe and his staff to discuss my medical care with the following individual(s) listed below. If there are any limitations on what we may discuss with these individuals, it must be received in writing and will be added to your file. This will remain in force unless revoked in writing.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____ _____

Signature Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify):

JASON D. ROE, DDS, FACP

Practice Policies

We are honored that you have chosen us to provide your dental care. We are here to help you and below are some general guidelines for our office

General

- Patients are seen by appointment only.
- Office hours are Monday through Thursday 8:00 – 4:00, and we are closed for lunch from 12:00 – 1:00.
- Cancellations within 24 hours of your appointment will be charged a fee of $100. If you need to cancel or reschedule your appointment, please verbally notify us at least 48 business hours in advance. We do not accept changes to the schedule on our voicemail system.
- "No Show" appointments will be charged your appointment fee in full starting with a minimum of $300.
- After the first "No Show" appointment, all other appointments will need to be pre-paid in full at the time the appointment is scheduled.
- If a patient has three (3) last-minute cancellations or missed appointments in a twelve month period of time, we reserve the right to terminate the patient/doctor relationship.
- As a courtesy to you, all appointments will receive a 2 week reminder from our office. At that time, we ask that you confirm the appointment, and update our office of any changes in your contact information, or insurance information.

Payments

- We accept American Express, Master Card, Visa and Discover
- For your convenience, our office offers third party financing through Care Credit Corporation and 12 month No Interest is available.
- Payments for services are to be paid at the time services are rendered.

Insurance

- To better assist you, we do require all insurance information and verification 48 hours prior to your appointment time.
- As we are not contracted with dental insurance companies, your insurance will reimburse you directly for services rendered in our office. We will file claims as a courtesy to you; however, all fees are ultimately the responsibility of the patient regardless of insurance.

_____ _____

Patient Name Date

_____

Patient Signature