J. Eric Hibbs, DDS, FAGD

www.ParkCitiesDental.com
5600 W. Lovers Lane @ Tollway #216
Dallas, TX 75209-4318 **214.351.2311**

Patient Information

Patient Name: _____
Last First MI Preferred Name

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

Social Security #: _____ Driver License #: _____(State)___ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: ___ Cell: _____ Pager: _____

Address: _____
Street Apartment # E-Mail Address

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street Suite# City State Zip Code

- How will you secure your account? ☐ Credit Card: _____ #: _____ Expires: _____
  ☐ I will pay for treatment at time of service during each visit.
- Reason for this visit: _____ Date of Last Dental Visit: _____

- Are you interested in: ☐ Fresher Breath ☐ Whiter Teeth ☐ Changing Appearance of Your Smile

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

☐ AIDS
☐ Allergies _____
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Sulfa Allergy
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Growths
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ **Pregnancy**
Due date:_____
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Venereal Disease
☐ OTHER:
_____
_____
_____

- What medications are you taking?_____ Why?_____
- Have you ever had any complications during or following dental treatment? ☐ No ☐ Yes: _____
- Are you now under the care of a physician? ☐ No ☐ Yes: Name: _____ Ph: _____
- Do you have any health problems that need further clarification? ☐ No ☐ Yes: _____
- Emergency Contact: Name of nearest relative not living with you? _____
  Complete address: _____ Phone: _____

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.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

How did you hear about our practice? Name: _____ ☐ Office Sign ☐ Post Card
☐ DallasYellow Pages ☐ Park Cities Yellow Pages ☐ Internet Web Site ☐ Other: _____

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

Phone #: _____ _____

Secondary (Additional Insurance)

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other: _____

Insurance Plan Name and Address: _____

Phone #: _____ _____

Minor Patient's Responsible Party Information

Name: _____

☐ Male ☐ Female Relationship to minor patient

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call:_____

Address: _____
Street Apartment #

_____
City State Zip Code

Consent for Services

As a condition of your treatment by this office, the patient is responsible for ensuring payment of the full fee charged for all treatment performed. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who require special financial arrangements must notify us in advance.

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 help prepare insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. **Estimates of patient co-pay amounts are not a gaurantee of the final amount due which will be determined and billed after all insurance payments have been received.**

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. If my account is secured by credit card, I hereby authorize any past due amounts to be charged to my securing card account.

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.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder, as allowed by state law.

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

I have read the above conditions of treatment and agree to their content.

_____ Date: _____ Relationship to Patient: _____

Signature of patient, parent or guardian