comaldental

family · cosmetic · implant

Welcome to our office! To assist us in serving you, please complete the following confidential forms

The information provided is important to your dental health.

Patient name _____ Birth date_____

If minor, parents names _____

Cell phone _____ Home phone _____

Work phone _____ Email Address _____

Mailing address_____

Emergency Contact name _____ Phone_____

Employer _____ Occupation_____

Whom may we thank for referring you to our office _____

BILLING AND INSURANCE INFORMATION ____ Not covered by dental insurance

Subscriber name _____ Subscriber SS# or ID#_____

Group number _____ Date of birth _____

Employer _____ Dental Insurance Co. _____

Insurance Co. phone _____

Secondary dental insurance YES NO

Subscriber name _____ Subscriber SS# or ID#_____

Group number _____

Employer _____ Dental Insurance Co. _____

Insurance Co. phone _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:

		YES	NO
1.	hospitalization for illness or injury _____	☐	☐
2.	an allergic or bad reaction to any of the following:	☐	☐
	○ aspirin, ibuprofen, acetaminophen, codeine _____		
	○ penicillin _____		
	○ erythromycin _____		
	○ tetracycline _____		
	○ sulfa _____		
	○ local anesthetic _____		
	○ fluoride _____		
	○ chlorhexidine (CHX) _____		
	○ Iodine _____		
	○ metals (nickel, gold, silver, _____)		
	○ latex _____		
	○ nuts _____		
	○ fruit _____		
	○ milk _____		
	○ red dye _____		
	○ other _____		
3.	heart problems, or cardiac stent within the last six months _____	☐	☐
4.	history of infective endocarditis _____	☐	☐
5.	artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6.	pacemaker or implantable defibrillator _____	☐	☐
7.	orthopedic or soft tissue implant (e.g joint replacement, breast implant) _____	☐	☐
8.	heart murmur, rheumatic or scarlet fever _____	☐	☐
9.	high or low blood pressure _____	☐	☐
10.	a stroke (taking blood thinners) _____	☐	☐
11.	anemia or other blood disorder _____	☐	☐
12.	prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13.	pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14.	chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15.	breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16.	sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17.	kidney disease _____	☐	☐
18.	liver disease or jaundice _____	☐	☐
19.	vertigo (e.g. "the room is spinning") _____	☐	☐
20.	thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21.	hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) _____	☐	☐
22.	high cholesterol or taking statin drugs _____	☐	☐
23.	diabetes (HbA1c = _____) _____	☐	☐
24.	stomach or duodenal ulcer _____	☐	☐
25.	digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

		YES	NO
26.	osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27.	arthritis or gout _____	☐	☐
28.	autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29.	glaucoma _____	☐	☐
30.	contact lenses _____	☐	☐
31.	head or neck injuries _____	☐	☐
32.	epilepsy, convulsions (seizures) _____	☐	☐
33.	neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _____	☐	☐
34.	viral infections and cold sores _____	☐	☐
35.	any lumps or swelling in the mouth _____	☐	☐
36.	hives, skin rash, hay fever _____	☐	☐
37.	STI/STD/HPV _____	☐	☐
38.	hepatitis (type ____) _____	☐	☐
39.	HIV/AIDS _____	☐	☐
40.	tumor, abnormal growth _____	☐	☐
41.	radiation therapy _____	☐	☐
42.	chemotherapy, immunosuppressive medication _____	☐	☐
43.	emotional difficulties _____	☐	☐
44.	psychiatric treatment or antidepressant medication _____	☐	☐
45.	concentration problems or ADD/ADHD _____	☐	☐
46.	alcohol/recreational drug use _____	☐	☐

ARE YOU:

47.	presently being treated for any other illness _____	☐	☐
48.	aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49.	taking medication for weight management _____	☐	☐
50.	taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51.	often exhausted or fatigued _____	☐	☐
52.	experiencing frequent headaches or chronic pain _____	☐	☐
53.	a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54.	considered a touchy/sensitive person _____	☐	☐
55.	often unhappy or depressed _____	☐	☐
56.	taking birth control pills _____	☐	☐
57.	currently pregnant _____	☐	☐
58.	diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE			
7.	Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing?	☐	☐
8.	Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing?	☐	☐
13.	Have you experienced a burning, painful sensation, or metallic taste in your mouth?	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT			
21.	Does your jaw joint ever have pain, sounds (popping, cracking), or experience limited opening or locking?	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34.	Have you ever bleached (whitened) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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Our Office Financial Policy

Thank you for choosing us as your dental health care provider. We believe that all patients deserve the very best dental care we can provide. The following is a statement of our Financial Policy which we require that you read and sign prior to any treatment.

FULL PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD,
DISCOVER AND AMERICAN EXPRESS CREDIT CARDS.
WE ALSO OFFER **CARE CREDIT** WHICH IS AN EXTENDED PAYMENT PLAN
WITH PRIOR CREDIT APPROVAL.

Regarding Insurance
We request than any co-payments, deductibles, and any services not covered by your insurance plan be paid at the time service is provided. The balance is your responsibility, whether your insurance company pays or not. We will assist you with an insurance claim, however, your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware some and possibly all of the services provided may be non -covered services and not considered reasonable, usual and customary under the terms of your dental policy.
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment Plans
Comal Dental has partnered with Care Credit, a patient financing company, to offer our patients deferred interest financing for 6 or 12 months, with approval. No other payment plans are available.

Returned Payment Fee
If any check or other payment that you have made to your account is returned unpaid, you will be charged a returned payment fee, which is currently $35 and may be adjusted.

No Waiver by us
We may waive our right to charge a fee to your account without waiving any other right we have under this financial policy.

Yes, I agree to the above terms and conditions.

_____ _____

Signature Date

Comal Dental
Aaron Haag, D.D.S., Sarah Hansen, D.D.S
2660 Common St. 102, New Braunfels, TX 78130
www.comaldental.com 830.625.1515

APPOINTMENT CANCELLATION POLICY

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set aside for you and when it is missed, that time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office 24 hours notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. A fee of **$50.00** will be charged to you; this fee cannot be billed to your insurance company and will be your direct responsibility.

If you have any questions regarding this policy, please let our staff know and we will be glad to clarify any questions you have.

I have read and understand the Appointment Cancellation Policy and I agree to its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, _____ (print name), have received a copy of Comal Dental

Appointment Cancellation Policy.

_____ _____

(Signature of Patient) (Date)

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HIPAA CONSENT

I hereby give permission for Comal Dental to release any and all medical, dental, and/or psychological reports or records, including, but not limited to, medical or dental notes, physician narratives, notes, operative notes, and discharge summaries. Doctor or dentist's orders, lab reports, test results, therapy progress notes, patient progress reports, diagnosis, post-operative reports, post-operative diagnosis, pathology reports, X-rays.

The release of the matters listed above is being authorized for purposes of obtaining medical or dental treatment. Any person, firm, or entity that releases matters pursuant to this authorization is hereby absolved from any liability that might otherwise result from the release of those matters. I further understand that I have the right to review COMAL DENTAL'S privacy notice and to request restrictions. I further understand that I may revoke this consent in the future if I should so desire.

_____ _____

Signature Date