



# Patient Information

Welcome to David de Jongh DDS and Houston Texas Dental Spa. Please fill out the information found below to the best of your ability and answer all health and beauty related questions to help us design the ideal experience for you. All information will remain confidential.

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ DL #: \_\_\_\_\_

Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ SSN: \_\_\_\_\_

Responsible Party: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Cell #: \_\_\_\_\_ Home #: \_\_\_\_\_ Work #: \_\_\_\_\_

Primary Email: \_\_\_\_\_  I would like to receive promotions and news via email

Preferred method of contact:  Cell  Home  Work  Email

Sex:  Female  Male Marital Status:  Single  Married  Widowed  Separated  Divorced  Prefer not to say

How did you hear about us?:  Google  Facebook  Instagram  Yelp  Other \_\_\_\_\_  Patient \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Policy Holder: \_\_\_\_\_

Policy Holder Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Policy Holder SSN: \_\_\_\_\_ Group Number: \_\_\_\_\_

ID Number: \_\_\_\_\_ Employer: \_\_\_\_\_ Secondary Insurance:  Yes  No

Please check all dental, pain management and esthetic services that are of interest to you.

### Dental

- All-On-Four/Six
- Anti-Aging Dentistry
- Bone Grafts
- Bonding
- Crowns/Bridges
- Deep Cleanings
- Dentures
- Extractions
- Full Mouth Rehab
- Gum Contouring
- Implants
- Invisalign
- Metal Free Dentistry
- Night Guards
- Oral Surgery
- Overbite Correction
- Perio Surgery
- Preventative Care
- Root Canals
- Sedation Denistry
- Sleep Apnea
- Smile Makeover
- Sports Guards
- Third Molar Surgery
- TMJ
- Tooth Colored Fillings
- Tooth Reshaping
- Underbite Correction
- Veneers
- Whitening

### Aesthetic

- Acne Treatment
- Botox Injections
- Brow Lift
- Cheek Augmentation
- Chemical Peels
- Chin Fat Reduction
- Dermal Filler
- Fractional Lasers
- Hydrafacial MD
- IPL
- Laser Genesis
- Laser Treatments
- LED Skin Therapy
- Lip Enhancement
- Liquid Facelift
- Non-Surgical Eyelift
- Pigment Removal
- Sun Damage Repair
- RF Microneedling
- Skin Contouring
- Skin Resurfacing
- Skin Tightening
- Scar Treatment
- Medical Facials/Peels

### Pain Management

- Botox Therapeutic for Chronic Migraine
- Botox Therapeutic for Cervical Dystonia
- Botox Therapeutic for TMJ

I, the undersigned, have insurance coverage with the company named above. I assign all medical benefits directly to Dr. de Jongh for all services rendered. I understand that I am financially responsible for all charges, including possible hospitalizations, whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all of my insurance submissions.

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



# Patient Health History

Welcome to David de Jongh DDS and Houston Texas Dental Spa. Please fill out the health history information found below to the best of your ability and answer all questions to help us design the ideal experience for you. All information will remain confidential.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

### IMPORTANT MEDICAL CONDITIONS (Please check each symptom that applies)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS, HIV Positive                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy, Seizures                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Phlebitis, Blood Clots |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol Abuse                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Excessive Bleeding                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alzheimer's, Dementia               | <input type="checkbox"/> Yes <input type="checkbox"/> No Fibromyalgia                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychological Problems |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anaphylaxis, Severe Allergy Attack  | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Cough                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation Treatments   |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia, Blood Disorder              | <input type="checkbox"/> Yes <input type="checkbox"/> No Frequent Nosebleeds                | <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Weight Gain     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angioedema, Swelling of Limbs       | <input type="checkbox"/> Yes <input type="checkbox"/> No GERD, Acid Reflux                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Recent Weight Loss     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ankle Swelling                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma, Eye Pressure             | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anorexia, Bulemia                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay Fever                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Joint Pain             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arthritis, Gout                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Head, Neck Pain                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Problems       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Heart Valve              | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack, Heart Problems       | <input type="checkbox"/> Yes <input type="checkbox"/> No Scarlet Fever          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Artificial Joint                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Murmur                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Snoring                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma, TB, Lung Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Shingles               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bell's Palsy, Neurological Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blood Transfusion                   | <input type="checkbox"/> Yes <input type="checkbox"/> No High, Low Blood Pressure           | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Body Dismorphic Disorder            | <input type="checkbox"/> Yes <input type="checkbox"/> No Hives, Rash                        | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Trouble          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bowel Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypoglycemia                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep Disorder         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bruise Easily                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Intestinal Disease                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Spina Bifida           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer, Melanoma, Tumors            | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Disease    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pains                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Edema, Poor Circulation            | <input type="checkbox"/> Yes <input type="checkbox"/> No Stiff Neck             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Back Problems               | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver Disease, Cirrhosis, Jaundice | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Fatigue                     | <input type="checkbox"/> Yes <input type="checkbox"/> No Low Blood Pressure                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid Disease        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Claustrophobia                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Lupus, Autoimmune Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No Tonsillitis            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cold Sores, Fever Blisters          | <input type="checkbox"/> Yes <input type="checkbox"/> No Migraines, Headaches               | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Congenital Heart Disease            | <input type="checkbox"/> Yes <input type="checkbox"/> No Muscular Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Degenerative Joint Disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No Pace Maker                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Vascular Disease       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Depression                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Pain in Jaw Joints, TMJ            | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes, Excessive Thirst          | <input type="checkbox"/> Yes <input type="checkbox"/> No Panic Attacks                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Yellow Jaundice        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Drug Abuse, Addiction               | <input type="checkbox"/> Yes <input type="checkbox"/> No Personality Disorder               |   |

Please list any other medical conditions from which you suffer: \_\_\_\_\_

### ALLERGIES & SENSITIVITIES (Please check all that apply)

- |  |  |
|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Acrylic       | <input type="checkbox"/> Yes <input type="checkbox"/> No Latex             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Aspirin       | <input type="checkbox"/> Yes <input type="checkbox"/> No Local Anesthetics |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chlorhexidine | <input type="checkbox"/> Yes <input type="checkbox"/> No Metal             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Codeine       | <input type="checkbox"/> Yes <input type="checkbox"/> No Penicillin        |

### FOR WOMEN: (Please check all that apply)

- |   |
|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pregnant; If yes, what is your due date? _____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Trying to Get Pregnant                         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Lactating                                      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Birth Control Medication                       |

I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed procedure and result in the forfeiture of any associated fees. I understand it is my responsibility to inform Dr. de Jongh and his staff of any changes in medical status.

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



# Pain & Headache Questionnaire

Welcome to David de Jongh DDS and Houston Texas Dental Spa. Please fill out the information found below to the best of your ability and answer all questions to help us design the ideal experience for you. All information will remain confidential.

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## CHIEF COMPLAINT

Describe what you think the problem is: \_\_\_\_\_

Describe what you think caused the problem: \_\_\_\_\_

When did this problem begin? \_\_\_\_\_

## HISTORY

How would you describe your overall physical health?  Poor  Average  Excellent  Other \_\_\_\_\_

How would you describe your overall dental health?  Poor  Average  Excellent  Other \_\_\_\_\_

Have you had any major medical or dental treatment in the last 3 years? If so, please explain: \_\_\_\_\_

Please list the name and phone number of any physician, dentist or other healthcare professional who is currently involved in your care: \_\_\_\_\_

Please list all medications or supplements you are currently taking: \_\_\_\_\_

Please list any medications you have previously taken: \_\_\_\_\_

Please check if you have received any of the following treatments:  Bite Splint  Botox Injections  Chiropractic Care

Cortisone Injections  Flexeril Injections  Ice/Heat Therapy  Massage Therapy  Occlusal Adjustment  Oral Appliance

Orthodontics  Physical Therapy  Surgery  TENS  Other \_\_\_\_\_

## INJURY & TRAUMA

Do you have a history of falls, accidents or injury that include the face or head? If so, please explain: \_\_\_\_\_

Do you perform any activity which stressed your hear, jaw or upper body? If so, please explain: \_\_\_\_\_

## DETAILS

Please check all that you experience:  Headaches  Migraines  Neck Pain  Head/Neck Tilt  TMJ  Spasms of neck, back muscles

Please rate the degree of current pain:  1  2  3  4  5  6  7  8  9  10

What is the frequency of your pain?  Daily  Weekly  Monthly  Semi-Annually



# Pain & Headache Questionnaire

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## DETAILS - CONTINUED

The pain is getting:  Better  Worse  Staying the same

What time of day does the pain usually begin?  Upon waking  Morning  Afternoon  Evening  Middle of the night  After eating

The pain is:  Continuous  Intermittent • How long does it usually last? \_\_\_\_\_

What is the quality of the pain? Check all that apply:  Sharp  Dull  Burning  Aching  Electrical  Other \_\_\_\_\_

What makes the pain better? \_\_\_\_\_

What makes the pain worse? \_\_\_\_\_

Does the pain come on its own or is it triggered? \_\_\_\_\_

Do you have any ear related pain? Has it been assessed? Please explain: \_\_\_\_\_

Do you have any of the following sounds in the jaw joint (Please specify right side, left side or both sides):

Clicking \_\_\_\_\_  Popping \_\_\_\_\_  Grinding \_\_\_\_\_  Other \_\_\_\_\_

Has your jaw ever locked closed/open?  Yes  No  Don't Know

How often does this occur?  Daily  Weekly  Monthly  Semi-Annually

Please explain how you were able to release your jaw from the locked position: \_\_\_\_\_

Please specify any other events or limitations associated with the use of your jaw: \_\_\_\_\_

For headache patients: How many days per month are you completely headache/migraine free? (No headache at all) \_\_\_\_\_

On average, how many hours per day do your headaches/migraines last? \_\_\_\_\_

Over the past three months, how has your headache/migraine frequency changed?  More often  Less often  No change

What symptoms do you normally have with your headaches/migraines? (Check all that apply)  Nausea  Vomiting  Sensitivity to light

Sensitivity to sound  Pain on one side or in specific areas  Pulsating pain  Radiating pain

How many days last month did you miss work or school due to your pain or headaches?  0  1-2  3-4  5+

How many days last month did you cancel plans due to your pain or headaches?

How many times last year did you go to the ER because of your pain or headaches?  0  1-2  3-4  5+

Are you aware of any postural issues related to your pain or muscle issues? (I.e. head tilt, forward lean, rotation, etc) If so, please explain: \_\_\_\_\_

Please list all surgeries, therapies, treatments or medications you have tried to alleviate your pain or headaches \_\_\_\_\_



# Pain & Headache Questionnaire

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## STRESS FACTORS

Please rate your stress level:  1  2  3  4  5  6  7  8  9  10

Are you aware of what is causing your stress?  Yes  No  Don't Know

How well would you say you manage your stress?  Very well  Moderately well  Poorly  Not at all

## HABITS

Do you clench/grind your teeth?  Yes  No  Don't Know

Do you sleep with an unusual head position?  Yes  No  Don't Know

Are you aware of any habits that may aggravate your condition? If so, please explain:

## SYMPTOMS (Please check each symptom that applies)

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Arm/finger tingling/numbness    | <input type="checkbox"/> Occipital headaches (back of head) | <input type="checkbox"/> Reduced mobility of jaw             |
| <input type="checkbox"/> Blurring of vision              | <input type="checkbox"/> Pain above or below eyes           | <input type="checkbox"/> Shoulder aches                      |
| <input type="checkbox"/> Ear pain                        | <input type="checkbox"/> Pain in cheek muscles              | <input type="checkbox"/> Soreness of neck muscles            |
| <input type="checkbox"/> Hissing/buzzing/ringing in ears | <input type="checkbox"/> Pain in forehead                   | <input type="checkbox"/> Stiffness of jaw                    |
| <input type="checkbox"/> Light sensitivity               | <input type="checkbox"/> Pain in temples                    | <input type="checkbox"/> Tightness of throat                 |
| <input type="checkbox"/> Limited ability to open mouth   | <input type="checkbox"/> Pressure behind eyes               | <input type="checkbox"/> Tooth pain                          |
| <input type="checkbox"/> Migraine headaches              | <input type="checkbox"/> Reduced mobility of head/neck      | <input type="checkbox"/> Uncontrollable jaw/tongue movements |

Please list any additional symptoms or details of your condition you would like us to know: \_\_\_\_\_

***I certify that the above is true, correct and complete. I am aware and accept that withholding information about my medical history could result in serious injury to me or harm to those involved in my care. I am aware that providing false or incomplete information about my medical and surgical history may result in the cancellation of my proposed procedure and also result in forfeiture of my fees.***

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

### **NOTICE OF PRIVACY PRACTICES FORM**

**This notice describes how medical information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.**

The Health Insurance Portability and Accountability (HIPPA) Act of 1996 is a federal program that required that all medical records and other individually identifiable health information, used or disclosed by us in any form, whether electronically, on paper or orally, are kept properly confidential. This act gives you, as the patient, significant rights to understand and control how your health information is used. HIPPA provides penalties for concerned entities that misuse personal health information.

As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

If you sign a consent form, we may use and disclose your medical records only for each of the following purposes: treatment, payment and health care options.

1. Treatment means providing, coordinating or managing health care and related services by one or more healthcare providers. An example of this would include a physical examination.
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
3. Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer services. An example would be an internal quality assessment review.
4. We may also create and distribute health information by removing all references to individual identifiable information.

We may, without prior consent, use or disclose protected health information to carry out treatment, payment or health care operations in the following circumstances:

1. In emergency treatment situations, if we attempt to obtain such consent as soon as reasonably practicable after the delivery of such treatment.
2. If we are required by law to treat you, and we attempt to obtain such consent but are unable to obtain such consent.
3. If we attempt to obtain your consent but are unable to do so due to substantial barriers to communicating with you and we determine that, in our professional judgement, your consent to receive treatment is clearly inferred from the circumstances.

We may contact you to provide appointment reminders or information about your treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following right with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

1. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
2. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
3. The right to inspect and copy your protected health information.
4. The right to amend your protected health information.
5. The right to receive an accounting of disclosures of protected health information.
6. The right to obtain a paper copy of this notice from us upon request.
7. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of the date it is signed, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protection has been violated. You have the right to file a formal, written complaint with our office or the Department of Health and Human Services. Please contact the Office of Civil Rights about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Name: \_\_\_\_\_

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

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

**HIPPA Consent**

I understand that under the Health Insurance Portability and Accountability (HIPPA) Act of 1996, I have certain rights regarding my protected health information. I understand that this information can and will be used, but is not mandatory for me to sign in order to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal healthcare operations such as quality assessments.
4. The day-to-day healthcare operations of the practice.

I have also been informed of and given the right to review and secure a copy of Houston Texas Dental Spa's Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that Houston Texas Dental Spa reserves the right to change the terms of this notice from time to time and that I may contact the office at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that Houston Texas Dental Spa is not required to agree with these requests. However, if both parties do agree, they are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Name: \_\_\_\_\_

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

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



### **TREATMENT CONSENT FORM**

What you are being asked to sign is a confirmation that we have discussed the nature and purpose of dental treatment, the known risks associated with dental treatment, the feasible treatment alternatives and that all your questions have been answered in a satisfactory manner. Please read this form carefully before signing and ask about anything you do not understand.

My signature at the bottom of this form certifies that:

I have been informed and understand that the practice of dentistry is not an exact science; no guarantees or assurance as to the outcome of prosthetic treatment or surgery can be made due to the uniqueness of every individual clinical situation. In most instances, the outcome of treatment is most satisfactory.

I understand that unforeseen conditions or circumstances may arise during the course of treatment and that additional treatment not specified in my treatment plan may be necessary. I will be advised of any additional treatment and estimated costs should the need arise.

I understand that the estimate given to me is for normal and usual treatment. I understand that if my treatment requires extra time, additional procedures or additional laboratory work, there may be additional fees.

I understand that Dr. de Jongh and his staff have carefully examined my mouth and recommended what the best possible form of treatment. Alternative treatment plans have been explained and I have been informed and understand the purpose and nature of the dental procedure. I understand the procedures that are necessary to accomplish completion of the dental treatment and fabrication of any necessary prosthesis.

I have been informed of the possible risks and complication involved with surgery, drugs and anesthesia that include but are not limited to the following: pain, swelling, infection, discoloration, inflammation of a vein, injury to teeth present, bone fractures, sinus penetration, delayed healing and allergic reactions to drugs or medications prescribed. Numbness of the lip, tongue, chin, cheek or teeth may also occur, for which the exact duration may not be determinable and may be irreversible.

I have been informed of the possible risks and complications involved with dental treatment that include but are not limited to: root canal therapy, fracture of teeth or roots, fracture of porcelain or acrylic, loss of cementation, decay around restorations and possible loss of teeth. I understand that these complications may necessitate further treatment.

I understand that if nothing is done, any of the following could occur: loss of teeth, loss of bone, gum tissue inflammation, infection, decay, sensitivity, looseness of teeth followed by the need for extraction, fracture of teeth and/or roots, difficulties in chewing and/or speech. Also possible are temporomandibular joint (TMJ) problems, headaches, referred pains to the back of the neck and facial muscles, and muscle fatigue when chewing.

Dr. de Jongh and his staff have explained that there is no method to accurately predict the outcome of dental treatment due to large variations in teeth, gums, bone, chewing forces and oral hygiene. It has been explained to me that in some instances dental treatment may not be successful.

I agree to follow the home care instructions provided to me. I agree to report to Dr. de Jongh for regular examinations as indicated and I understand that this office will monitor my progress unless I have been advised to return to my general dentist for care.

To my knowledge, I have given an accurate report of my physical and mental health history. I have also reported any prior allergic or unusual reactions to drugs, food, insect bites, anesthetics, pollens, dust and blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my health.

I consent to photography, study models and x-rays of the procedure to be performed for use in teaching dentistry and other graphic purposes.

I understand that with any dental treatment, my teeth, gums or bone can be damaged by bacteria and I must do my best to remove the bacterial plaque off all the surfaces of my teeth and/or prosthetics every day. If I do not clean my dentition properly, I may get decay and/or gum disease and my treatment may fail.

I understand that it is my responsibility to comply with recommended treatment protocol and return in a timely fashion for any follow up appointments necessary to complete treatment. If I fail to do so, my treatment may be terminated at the discretion of the Houston Texas Dental Spa. I understand that I am not entitled to a refund for any work that has been initiated.

I understand and authorize the taking of clinical photographs and videos for educational, scientific and/or marketing purposes, both in publications and presentations. I hold Houston Texas Dental Spa harmless for any liability resulting from this production. I waive my rights to any royalties, fees and inspection of the finished production as well as advertising materials in conjunction with these photographs.

I have been fully informed of the nature of dental treatment along with possible risks and complications and hereby consent to treatment. I also state that I read and write in English.

Name: \_\_\_\_\_

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

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

**OFFICE FINANCIAL POLICY AGREEMENT**

It is our belief that all of our patients deserve the best possible dental care we provide. Part of that care is that making necessary financial arrangements prior to beginning treatment so that the treatment plan selected can move forward without hesitation. We feel that everyone benefits when office policy and financial arrangements are clearly understood. In keeping with this belief of ensuring all parties have a definitive understanding of payment for dental services provided, the following is the Houston Texas Dental Spa office financial policy.

We offer three convenient payment methods to assist our patients:

1. Payment in full at the beginning of the appointment during which services are rendered. We accept cash, check, Visa, Mastercard or American Express.
2. No interest payment plan options for 6 months through Care Credit or Lending Club.
3. Extended payment plan options through Care Credit or Lending Club.

As a courtesy to you, our office will be happy to file your claim with your insurance company or provide the forms for you to do so yourself. Please note that all payments made for services that have been initiated are non-refundable, and it is your responsibility to complete treatment in a timely fashion. Should a patient fail to complete treatment in a reasonable amount of time or comply with recommended treatment protocol, Houston Texas Dental Spa reserves the right to terminate treatment at our discretion with no refund. Full fees may be required to initiate treatment at a later date.

I understand that I am responsible for payment of all fees at the beginning of the appointment during which services are rendered, regardless of insurance coverage, including any legal and/or other costs incurred in the collection of this account, should it become delinquent.

I have read the above policies and accept responsibility of payment for any work incurred at this office.

Name: \_\_\_\_\_

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

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

**RESCHEDULING POLICY AGREEMENT**

We appreciate you business! In an effort to best serve all out patients, please be advised of these policies:

**Arrival Time:** Please aim to arrive 10-15 minutes prior to your scheduled appointment time. If you arrive after your scheduled appointment time, it may not be possible to extend the time available for your booked service, and on some occasions rescheduling may be necessary. If your service is shortened due to your late arrival, you will still be charged the full cost of the service.

**Changing Your Appointment:** Houston Texas Dental Spa requires 24 hours' notice to reschedule or cancel a booked appointment, except in rare cases of emergency and/or contagious illness as described below. If you fail to notify our office more than 24 hours ahead and/or miss your appointment without proper notification, you will be charged a \$50 fee for the failed appointment. Please be aware that we do not accept appointment changes or cancellations via email or text message.

**Sickness or Family Emergency:** If you, or another person in our household have an infectious or contagious illness, please contact us as soon as possible to reschedule your appointment for a later date.

**Please be courteous and take a few moments to notify our office in a timely fashion regarding any changes in your schedule and we will be happy to make accommodations to assist you when possible.**

Name: \_\_\_\_\_

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

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