WELCOME to ACE DENTAL

Thank you for your interest in our office. Our commitment is to provide you the highest standard of personalized dental care. We trust you will find the atmosphere calming, the staff friendly and our dental services exceptional.

OUR SERVICES:
We provide diagnostic, preventive, restorative and comestic dental care for you and your family, using today's most advanced dental technology, equipment and materials.

APPOINTMENTS:
Appointment times are designed to fit your specific dental needs and help to ensure a postive dental experience.

Walk-ins are welcome. We will provide the needed treatment if time allows. If you are in pain, we will get you out of pain and reschedule for proper treatment at a later date.

PAYMENT OPTIONS:

We accept Cash, Visa and Mastercards **. We do not accept checks.**

Payment is expected when dental service is provided, unless previous arrangement has been made.

INSURANCES:
Our goal is to maximize your insurance benefits and make any remaining balance easily affordable.
We will verify insurance coverage as a courtesy to our patients**.** All insurance companies unambiguously quote that "Verification is not a guarantee of benefit payment". Every insurance, employer and individual coverage plans are different and we in our office do not have the man power to verify every such plan or coverage in detail.

Upon verification of your dental coverages, we will complete and bill the insurance company as a courtesy to our patients. Any amount not covered by your dental plan such as deductible or co-insurance will be collected at the time of service. **You will be responsible for any additional balances after your insurance payment is received**.

CANCELATION:
Please notify us within **24 hours** of your reserved appointment if you must cancel. This will allow us to accommodate another patient at that time.

***Saturday appointments cancellation day OF will result in NO appointments made on future Saturdays.**

A service fee of $25.00 will be charged to your account for all NO SHOW and CANCELATION without notice.

Relationship To Patient. _____

Signature:_____**Print Name** _____**Date**:_____

Ace Dental
713 Hebron Parkway #216
Lewisville TX 75057

Date:_____

Patient Information (CONFIDENTIAL)

Name_____Home Phone_____
Address_____City_____State_____Zip Code_____
Date of Birth_____ Sex: ❑M ❑F Soc. Sec. No_____
Check appropriate box: ❑Minor ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated
Patient's Employer/School_____Work Phone_____
Email Address_____ Emergency Contact_____( ) -_____
Whom may we thank for referring you?_____

Responsible Party (Ex: Parents, Spouse, Caregiver, Nursing home, P.O.A, etc.)

Name of person responsible for this account_____
Relationship to Patient _____Home Phone_____
Address_____
Soc. Sec. No._____ Birthdate_____
Employer_____Work phone_____
Is this person currently a patient in our office? ❑Yes ❑No

Dental Insurance Information:

Name of Insured _____ Relationship to Patient_____
Subscriber's Birthdate_____Soc. Sec. No._____
Name of Employer _____Work Phone_____
Name of Dental Insurance Co. _____Group No._____
Ins. Co. Address_____City_____State_____Zip code_____

Do you have additional dental insurance? ❑Yes ❑No If yes complete the following:

Name of Insured _____ Relationship to Patient_____
Subscriber's Birthdate_____Soc. Sec. No._____
Name of Employer _____Work Phone_____
Name of Dental Insurance Co. _____Group No._____
Ins. Co. Address_____City_____State_____Zip code_____

Medical History:

	Yes	No
1) Are you under medical treatment now?	❑	❑
2) Have you ever been hospitalized for any surgical operations or serious illness?	❑	❑
3) Are you taking any medication(s) **including non-prescription** medications?	❑	❑
If yes, please list **all** medications you are currently taking: _____ _____ _____		
4) Do you use tobacco?	❑	❑
5) Do you use alcohol, cocaine or other drugs?	❑	❑
6) Do you take an **aspirin daily**? ____mg	❑	❑
7) Are you allergic to any of the following:		
Local anesthetics (ex. Novocain)	❑	❑
Penicillin or other antibiotics	❑	❑
Sulfa drugs	❑	❑
Barbiturates	❑	❑
Sedatives	❑	❑
Iodine	❑	❑
Aspirin	❑	❑
Other _____	❑	❑
8) Women only		
Are you pregnant or think you may be pregnant?	❑	❑
Are you nursing?	❑	❑
Are you taking birth control?	❑	❑

Do you suffer from any of the following?

	Yes	No
High Blood Pressure	❑	❑
Heart attack	❑	❑
Low blood pressure	❑	❑
Heart disease	❑	❑
Cardiac pacemaker	❑	❑
Heart Murmur	❑	❑
Rheumatic Fever	❑	❑
Fainting	❑	❑
Asthma	❑	❑
Epilepsy/Convulsions	❑	❑
Leukemia	❑	❑
Diabetes	❑	❑
Kidney Diseases	❑	❑
HIV/AIDS	❑	❑
Radiation Therapy	❑	❑
Anemia	❑	❑
Emphysema	❑	❑
Cancer	❑	❑
Hepatitis	❑	❑
Liver Disease	❑	❑
Joint Replacement	❑	❑
Stroke	❑	❑
Tuberculosis	❑	❑

Please list any others:
_____
_____

Dental History:

1) Are your teeth sensitive to hot, cold, sweet or sour liquid/food?
2) Do you feel pain in any of your teeth?
3) Have you ever had difficult extractions in the past?
4) Have you ever had prolonged bleeding following and extraction?
5) Are you currently wearing dentures?
   Age of existing dentures:_____ years old
6) Date of last x-ray series is _____
   How many were taken?_____

Authorization and Release

I confirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental service I may need. My method of payment will be _____. I certify that I am covered by _____ Insurance Company and I assign directly to this dental office all insurance benefits, otherwise payable to me. I understand that I am responsible for payment of service rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electric. By signing my signature, I have read and understand all of the above.

Signature:_____Date:_____

Ace Dental
713 Hebron Parkway #216
Lewisville TX 75057

Date:_____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE DOWNLOAD A FULL DOCUMENT FROM OUR WEBSITE AND READ IT AND REVIEW IT CAREFULLY.

By law we are required to provide you with our Notice of Privacy Practices (NNP). This notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information.

As a patient you have the following rights:
The right to inspect a copy of your information;
The right to request corrections to your information;
The right to request your information is restricted;
The right to request confidential communications;
The right to a report of disclosures of your information; and
The right to a paper copy of this notice.

We want to assure you that your medical protected health information is secure with us. This Notice of Privacy Practices contains information about how we ensure that your information remains private.

Acknowledgement of Notice of Privacy Practices

I hereby acknowledge that I have reviewed this practice's Notice of Privacy Practices. I further understand that the practice will offer me updates to this notice. Should it be modified or changed in any way I will receive a copy.

_____

Printed name of Patient

_____

Signature of Patient/Parent/legal Guardian

_____

Date

Ace Dental
713 Hebron Parkway #216
Lewisville TX 75057

Date:_____

PATIENT PAYMENT AGREEMENT

Thank you for the opportunity to help you meet your oral health goals. During our discussion of your treatment recommendation, the following financial arrangements were made:

The cost of treatment with Dr. Reddy is $_____. It is estimated that your insurance will cover $_____ and patient responsibility for treatment is $_____.
Once dental treatment has begun, changes in the anticipated treatment plan may be required, depending on oral conditions encountered. We will inform you if this occurs and you will be given the option of continuing or changing treatment. _____

(Patient initials)

I have discussed payment options and agreed upon a payment plan with the insurance company and with the undersigned provider. In the case that my insurance does not reimburse the full amount noted on the Treatment Plan, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.
As you know, it is this practice's policy to receive payment prior to completion of treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. You have agreed to pay your patient portion of the treatment fee in the following way:

[ ] Payment in full in the amount of $_____
Paid with: _____
[ ] Deposit required: $_____
Deposit paid with: _____
[ ] Remaining treatment fee: $_____
[ ] To be paid by: _____ with _____
[ ]___ Equal payments of $_____

If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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Patient, Parent or Guardian Signature Date

Patient Name (Please Print)