MOBERI DENTAL SPECIALISTS
UNPARALLELED COMMITMENT | UNCOMPROMISED CARE

Asstnt receives patient at: _____

Assistant initials: _____

Pt introduced to Dr. Mo at: _____

TX completed :_____ At:_____

HEALTH HISTORY FORM

Name:_____ _____

FIRST LAST

Please answer all questions:

YES	NO	
__	__	Are you presently in pain?
__	__	Are you taking blood thinners?

Pain level in the scale 1-10. ____

Anxiety level 1-10 _____

10 Being the worst

Have you ever had the following:

YES	NO		YES	NO	
__	__	Hepatitis A B C	__	__	Heart Trouble
__	__	Tuberculosis	__	__	Rheumatic Fever
__	__	Kidney Trouble	__	__	Phen/Fen
__	__	Liver Trouble	__	__	TMJ Disorder
__	__	Diabetes	__	__	Arti. Joints
__	__	Allergies	__	__	HIV, AIDS
__	__	High Blood pressure	__	__	Cancer Therapy

Have you ever had a reaction to the following:

YES	NO	
__	__	Latex
__	__	Penicillin
__	__	Local anesthetic
__	__	Antibiotics
__	__	Pain Med/Other

Is there any other information about your health we should know?

DO YOU REQUIRE PREMEDICATION WITH ANTIBIOTICS FOR ANY OF THE FOLLOWING REASONS?
(CHECK ALL THAT APPLY)

__ Artificial Joints

__ Heart Condition(s)

__ Rheumatic Fever

Cardiologist Name:_____

Phone No._____

List of all Current Medications:

_____

_____

_____

_____

_____

_____

_____

_____

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HEALTH HISTORY FORM

TO ASSIST US IN UNDERSTANDING AND DIAGNOSING YOUR DENTAL CONDITION, PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR ABILITY

Please list ALL your operations, surgeries, and hospitalization **with complications: (don't list if you did not have complications):**

Are you now under a physician's care, or have you been during the past five years, including hospitalization and surgery?

Have you taken Cortisone or other steroids in the past 24 months?	☐ Yes	☐ No
Have you had ophthalmic (eye) surgery in the past 8 weeks?	☐ Yes	☐ No
Have you or your family had a reaction to any dental or general anesthetic?	☐ Yes	☐ No
Have you had any adverse effects to dental treatment?	☐ Yes	☐ No
When you walk upstairs to take a walk, do you ever have to stop because of pain chest, shortness of breath, or because you are very tired?	☐ Yes	☐ No
Are you in good health?	☐ Yes	☐ No
Has there been ANY change in your general health in the past year?	☐ Yes	☐ No

Date of last physical exam: _____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, abnormal tests, or if my medicines change, I will inform the doctor at the next appointment without fail. I have had a chance to ask questions. I understand x-rays and local anesthetics may be required for treatment.

I also state that I read and write English or this information has been translated to me in my primary language.

Signature of Patient/Guardian _____ Date:_____

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HEALTH HISTORY FORM

WOMEN:

Are you pregnant? ☐ Yes ☐ No

How far along:_____

If yes, are you currently nursing? ☐ Yes ☐ No

If no, could you be pregnant or do you anticipate becoming Pregnant in the upcoming year? ☐ Yes ☐ No

Are you using birth control pills, patches, or shots? ☐ Yes ☐ No

Disclaimer: If you are using birth control pills it is important that you understand that antibiotics and other medications may interfere with the effectiveness of oral contraceptives. Please consult with your physician for assistance regarding additional methods of birth control.

Disclaimer: If you are pregnant, or POSSIBLY pregnant or trying to become pregnant, surgery, anesthetics or any other medications may significantly harm your developing baby, especially during the first trimester. Please advise your doctor if there is any change of your being pregnant.

Signature of Patient/Guardian _____ Date:_____

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INFORMED CONSENT FOR ENDODONTIC TREATMENT

The Medical Consent Law requires doctors to advice patients of the general nature of the treatment procedures, the acceptable treatment alternatives, and the risks inherent in the proposed procedures.

I voluntary consent to endodontic (root canal) treatment that has been recommended. I understand that the goal of a root canal treatment is to save a tooth that might otherwise require extraction. Although root canal treatment has a very high success rate it, is a dental-biological procedure, whose results cannot be guaranteed. Further, root canal treatment is performed to correct an apparent problem; and occasionally undiagnosed or hidden problems arise. I understand that this procedure will not prevent future tooth decay or possible fracture, and that occasionally a tooth that had a root canal treatment may require re-treatment, surgery, or tooth extraction.

The treatment has been fully explained to me including the risks involved. I have been informed that complications might include, but are not limited to:

a) Perforation of the canal with instruments, which could result in the need for root canal surgery or the loss of the tooth.
b) Instrument breakage in the canal, which may require re-treatment, root canal surgery, or extraction.
c) Incomplete healing, which may require re-treatment and/or root canal surgery or extraction.
d) Post-operative infection, which may require additional treatment or tooth extraction.
e) Referral to a specialist if any unexpected difficulties occur during the treatment.
f) Post-treatment discomfort altered feeling of the soft tissues of the mouth.
g) If the tooth has a crown, crown breakage or dislodged might occur, and crown replacement might be recommended. The cost of the post-treatment restorations are the patient's responsibility.

I am aware that the condition of the tooth will worsen and that other systemic (medical) problems could possibly develop if the recommended procedure is not done. It has been explained that other treatment options might be possible, such as, tooth extraction, and followed by fixed or removable bridge-work, or placement of dental implants.

After the completion of the root canal procedure, you will be referred back to your restorative dentist for the permanent restoration (filling, crown, onlay). Failure to have the tooth properly restored significantly increases the possibility of re-infection, failure of the root canal procedure, and/or tooth fracture.
I had an opportunity to ask questions of my doctor and am fully satisfied with the answers that I have received.

Signature of Patient/Guardian _____ Date:_____

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NITROUS OXIDE INFORMED CONSENT FORM

The Purpose of this consent form is to provide an opportunity for patients (and/or their parents/ guardians) to understand and give permission for the use of Nitrous Oxide when provided along with dental treatment. Each item should check off after the patient/guardian has had the opportunity for discussion and questions.

1. I accept and understand that Nitrous Oxide is commonly known as laughing gas and provides relaxation, although I will be awake, fully conscious, aware of my surroundings and able to respond rationally to inquiries and directions.
2. I accept and understand that the use of Nitrous Oxide **is not required to provide the necessary dental care and has an additional cost to the treatment that insurance companies do not cover And has a cost of $125.**
3. I accept and understand that the purpose of Nitrous Oxide is to make it more comfortable for me to receive the necessary dental care with less pain and/or anxiety. I also accept and understand that the use of Nitrous Oxide has limitations and risks and absolute success cannot be guaranteed.
4. I accept and understand that Nitrous Oxide will be administered by way of inhalation route.
5. I accept and understand that the alternatives to Nitrous Oxide are:
   a. No Nitrous Oxide: The necessary procedure is performed under local anesthetic only.
   b. Anxiolysis: A pharmacologically induced state of consciousness where an individual is awake but has decreased anxiety to facilitate coping skills, retaining interactive ability.
   c. Oral Conscious Sedation: Sedation via pill form that will put me in a minimally depressed level of consciousness.
   d. Intravenous (IV) Sedation/General Anesthetic: Commonly called deep sedation or general, a patient is under general anesthetic has no awareness and must have his/her breathing temporarily supported. General Anesthesia is more appropriate for more invasive procedures.
6. I am aware that temporary complications may include, but not exclusive of: tingling in the fingers, toes, cheeks, lips, tongue or head area; heaviness in the thighs/ legs, followed by a lighter floating feeling; resonation in the voice or presence of hyper nasal tone; warm feeling throughout the body; lightweight or floating sensation with an accompanying “out of body” sensation; sluggishness in motion and slurring and/or repetition of words; feeling of nausea; vomiting; agitation; and/or hallucination. **All these complications are temporary.**
7. I have had the opportunity to discuss the Nitrous Oxide in conjunction with my dental care, and have had an opportunity to ask questions and am fully satisfied with the answers I received.
8. I accept and understand that I must follow all recommended instructions.
9. I have informed the doctor of my complete medical history including any recent surgeries or changes in my medical history involving lung, respiratory, ear infection or common cold. I also accept and understand that I must notify the doctor of my present mental and physical condition.
10. I accept and understand that I must notify the doctor if I: (1) am pregnant, (2) have sensitivity to any medications, (3) have recently consumed alcohol, and/or (4) am presently on psychiatric mood altering drug or other medications.

Patient/Guardian’s signature _____ Date:_____

Dental Assistant: _____

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Privacy Consent

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:

- ✓ Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- ✓ Obtain payment from third-party payers.
- ✓ Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you and your NOTICE OF PRIVACY PRACTICES containing a more complete description of the uses and disclosures of my health information. I have been given the right of review such NOTICE OF PRIVACY PRACTICES prior to signing this consent.

I understand that this organization has the right to change its NOTICE OF PRIVACY PRACTICES from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the NOTICE OF PRIVACY PRACTICES.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Signature of Patient or Guardian:_____Date:_____

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Patient Survey

Name: _____

How did you first hear about us?

- Don't remember
- Friend or family member
- Community newsletter
- Referring Dental office name:_____
- Social Media
- Dental insurance company
- Other: _____

Financial, Insurance Agreement and Patient Billing Policies

Financial Options
We would like to provide you with information about our office financial policy before your visit. Unlike your general dentist, as a specialty practice, we may only see you as our patient for one treatment visit. Therefore, payment is due at the time services are rendered. As a courtesy, if you have dental insurance we will bill your carrier, provide documentation, claim forms, radiographs, and treatment narratives. We will request that you pay your estimated co-payment at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express. We also offer financing and payment plans which can be arranged in advance, prior to your appointment. ***Our only payment plan, Care Credit a dental credit card, is hassle-free and extends payments to fit comfortably within your budget with up to 12 months without interest. Please ask us if extending payment is important for you.***

Insurance
The main thing to understand about your insurance coverage is that it is a contract between you, your employer and the insurance company. We will verify your coverage and give you an estimate of what your out of pocket expense should be. Your estimated co-payment is due at the time services are rendered.

For In-network insurance patients; your plan will have eligible benefits for most services provided. We have no control over what your plan covers or how much it pays for any procedure. The cost of any uncovered procedure will be your responsibility.

For those patients whose plans that are Out-of Network, we request 50%payment for our professional services at time treatment is rendered.

We strive to help you maximize your benefits, and can expedite the reimbursement process by electronically filing your claim on your behalf as a courtesy to you. You also have the option of paying for your treatment in full at the time services are rendered and filing your claim on your own for direct reimbursement. In any event, entire payment is expected to be paid in full within 6 weeks of treatment rendered.

Billing
In order to ensure the remaining percent of the fee is received, a credit card pre-authorization form will be completed, granting James C. Morrison Jr., D.M.D PA permission to charge the remaining balance or credit to your credit card. Most insurance companies will respond within 4-6 weeks. We will send you a statement if necessary. Please contact our office at 281-855-3380 if your statement does not reflect your insurance compensation within that time frame. Any remaining balance after your insurance has paid is your responsibility. Your prompt remittance is appreciated.

By signing this document verifies that I have fully read and understand its purpose contents.

_____
Patient or Guardian's Printed Full Name

_____ _____
Signature of Patient or Guardian Date

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REQUIRE FOR ALL INSURANCE PATIENTS

CREDIT/DEBIT CARD AUTHORIZATION FORM

CARD THAT WILL BE USE TO PAY FOR SERVICES TODAY AND FOR OPEN BALANCES

I, _____, authorize James C. Morrison, Jr. DMD PA to charge the amount due on my account; upon determination and payment of explanation of benefits from your insurance company; without me being present at the office at the time of the payment. I certify that the information on this form is correct and true, and will notify James C. Morrison Jr., DMD PA immediately of any changes.

CIRCLE CARD TYPE:

AMEX - DISCOVER - MC - VISA - CARE CREDIT - FLEX CARD- HEALTH SAVINGS

Card # _____

Credit card Exp Date: _____

Card Holder Name: _____

Drivers License # _____

Card Holder Signature: _____

Card Holders Address: _____
(If different from patient)

City: _____ ST_____ Zip _____

Email: _____

This application shall apply indefinitely unless revoked by the cardholder in writing. James C. Morrison, Jr, DMD PA reserves the right to discontinue such payment method at any time. James C Morrison, Jr, DMD PA reserves the right to charge a service fee for any Rejected/ Declined or NSF transactions. I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.