Lloyd Laughlin, D.D.S., F.A.G.D., P.A.
4500 East Sam Houston Parkway, Suite 200
Pasadena, Texas 77505

Patient Information Date:_____

Name:_____ Married? Y / N Minor? Y / N Male / Female ?
Last First M.

Address_____
Street Apt.# City State Zip

Birth date _____ Telephone _____
Month Day Year Home Work Cell

Email Address_____ Fax# _____

Place of Employment_____ SSN _____

If Full Time Student, School Name _____ Grade _____

Person Responsible For Account- Please Circle One: Patient Guardian Spouse Father Mother

Insurance Information Primary Insured / If No Insurance, Complete For Responsible Party

_____ _____
Last First M. Street City State Zip

_____ _____
Home # Work # Fax # Birthdate (Mo./Day/Year) Relationship to Patient

_____ _____
Employer Dental Insurance Company Phone # SSN Subscriber# Group #

Person To Contact In Case Of Emergency (Outside of Immediate Family Household)

Name_____ Telephone # _____

Address:_____ City/State/Zip_____

Has any member of your family ever been treated in our office? Yes No

Whom may we thank for referring you to our office? _____

Authorization

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, pholographic, and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals.

X_____ _____
Patient or Responsible Party Date State Driver's License #

Lloyd L Laughlin DDS

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Patient Name	DENTAL HISTORY
Patient Account No.	Medical Alert

Welcome! So that we may provide you with the best possible care
please complete both sides of this medical/dental history form.
All information is completely confidential.

What is the reason for you visit today? _____

_____

Date of Last Dental Visit _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____
What was done at your last dental visit? _____

_____

Previous Dentist's Name _____
Address _____ State _____ Zip _____
Telephone _____

How often do you have dental examinations? _____
How often do you brush your teeth? _____ How often do you floss? _____
What other dental aids do you use? (Interplak, toothpick, etc.) _____

Do you have any dental problems now? Yes No
If yes, please describe: _____

Are any of your teeth sensitive to:		
Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters or any other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught in between your teeth?	Yes	No

If yes, where? _____

Do you:		
Clench or grind your teeth while awake or sleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, fingernails)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:		
Orthodontic treatment?	Yes	No
Oral surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause _____

_____

Have you experinced:		
Clicking or popping of the jaw?	Yes	No
Pain? (joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Headaches, neckaches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	**Yes**	**No**
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

_____

Have you ever had an upsetting dental experience? Yes No
If yes, please describe _____

_____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe: _____

_____

_____

_____

(Please complete other side)

Lloyd Laughlin, D.D.S., F.A.G.D., P.A.,

Authorization and Acknowledgement

I hereby authorize the office of Lloyd Laughlin, D.D.S., F.A.G.D, P.A. to release information acquired in the course of my treatment to my insurance company, employer-based dental plan, or third party payer as required of claims filed, quality assurance, dental plan administration, complaints/grievances.

I authorize direct payment to be made to the office of Dr. Lloyd Laughlin, D.D.S., F.A.G.D, P.A.. for all dental and orthodontic services rendered. I understand that I am responsible for all charges if any services are not covered by insurance, or if our office is unable to verify eligibility. I understand that my insurance plan may not always cover services based on diagnosis and need, but rather how my employer has set up benefits to be paid.

Financial Policy

Thank you for choosing Lloyd Laughlin, D.D.S., F.A.G.D, P.A.. for your dental care needs. Please carefully review our financial policy. If you have any questions, feel free to give us a call! We can be reached during business ours at 281-998-4916. Monday, Tuesday, Wednesday: 8 AM-5 PM Thursday: 9 AM- 6 PM Friday: (closed) office staff available 8 AM-12 PM.

Insurance Services

Our office does participate with some insurance plans, but we can still accept most insurance plans with options to choose your own dentist; however, it is ultimately your responsibility for the full and timely payment of your account. We allow 60 days for claims to be paid, and then it becomes your responsibility to contact your insurance company for further correspondence.

Please be prepared to submit your current insurance card at your visit, and a copy will be scanned in to your permanent record. Please also provide our office with up to date contact information including your home address, telephone number, and emergency contact information.

Our office will attempt to verify coverage and benefits prior to your visit. If we are unable to obtain verification of coverage you may be asked to pay in full or reschedule your appointments for a time when the verification can be obtained. This verification will be used to estimate your financial responsibility, but is never a guarantee by your dental plan of coverage or payment.

Payment of your estimated patient liability is expected at the time services are rendered. This payment will include known deductibles, co-pays, and coinsurance due for this appointment. While we may estimate your financial responsibility, it is the insurance company that makes the final determination regarding your eligibility and benefits. In the event that your insurance company fails to pay, all in or part, you will be expected to pay the balance in full.

(01/2009)
(Amended 01/2010)

Please be aware that certain office procedures or services may not be covered, or may be considered "not medically necessary", "experimental", or "cosmetic" by your dental plan. You are responsible for payment of these services. ***Please also be aware that many dental plans limit preventive / annual coverage. In the event your care exceeds a plan limitation, you will be responsible for the balance. It is your responsibility to know the benefits and limitations of your current dental health care plan.*** Dr. Laughlin will provide dental/medically necessary care based on patients' dental needs, not a patient's insurance coverage. **Your dentist is not responsible for knowing your plan's specific benefit and coverage limitations.**

Our office does not submit claims to secondary insurance plans, or third parties involving accidents and accidental injury. An itemized statement may be obtained by calling our office. This statement will assist you with reimbursement. It is your responsibility to file claims in these instances.

Failure to Cancel Appointment/ No Shows

If you or your child has an appointment with Dr. Laughlin, or has a scheduled hygiene appointment, you must give cancellation notice of at least **24 hours.** As a courtesy, we attempt to call our patients and remind them of their appointments. However, if we are unable to contact you, it is your responsibility to keep your appointments or call to cancel.
ALL APPOINTMENTS CANCELLED LESS THAN 24 HOURS BEFORE SCHEDULED TIME WILL REQUIRE PRE-PAYMENT IN ORDER TO BE RESCHEDULED.
(effective: 01/2010)

There will be a no-show/cancellation fee of $25 billed to you.

Past Due Accounts

If your account becomes past due we will take necessary steps to collect this debt. Referral to a collection agency may adversely impact your credit record. Accounts turned over to collection agencies may also result in you being dismissed from our office. In the event a patient is dismissed for non-payment, services will no longer be provided.

NSF/Denied Credit Card Payments

If a check is returned for insufficient funds, account closed, or payment is stopped, your account will be charged a $30.00 fee. This fee applies to payments made at our front desk, or mailed in with statements. In the unlikely event that this happens, you will be required to pay by cash. We will be unable to accept checks or credit cards from you.

Again, thank you for choosing Lloyd Laughlin, D.D.S., F.A.G.D, P.A. for all your family's dental needs! We appreciate the opportunity to serve you.

I acknowledge receipt of Dr. Laughlin's financial policy.

I acknowledge prior receipt of a Notice of Privacy Practices and that no warranty or guarantee has been made to me as a result or cure. I certify that I understand this statement.

Date:
Patient Name:

Signature:

Lloyd L. Laughlin, D.D.S., F.A.G.D., P.A.
4500 East Sam Houston parkway, Suite 200
Pasadena, Texas 77505

Patient Consent Form

I understand that under the Health Insurance Portability & 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, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and/or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of 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 to 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 above 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, then you are bonded 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.

Patient Name: _____

Signature: _____ Date: _____

Relationship to Patient: _____

Lloyd L. Laughlin D.D.S., P.A., F.A.G.D., P.A.
4500 East Sam Houston Parkway, Ste 200
Pasadena, Texas 77505

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____