

# Ashly Cothorn, D.D.S.

9669 N. Central Expressway • Suite 220 • Dallas, Texas 75231  
214-696-9966

## PATIENT INFORMATION

Name(First, Middle initial, Last) \_\_\_\_\_ Preferred Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Social Security # \_\_\_\_\_  
M \_\_\_\_\_ F \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Single \_\_\_\_\_  
Employed by \_\_\_\_\_ Phone# \_\_\_\_\_  
Address \_\_\_\_\_ Occupation \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ E-mail \_\_\_\_\_  
Would you like to receive text message reminders?      Y      N      Would you like to receive email reminders?      Y      N

## SPOUSE OR RESPONSIBLE PARTY

Name(First, Middle initial, Last) \_\_\_\_\_ Relationship to patient \_\_\_\_\_  
Address \_\_\_\_\_ Phone # \_\_\_\_\_  
City, State, Zip \_\_\_\_\_ Social Security # \_\_\_\_\_  
Employed by \_\_\_\_\_ Phone # \_\_\_\_\_  
Address \_\_\_\_\_  
City, State, Zip \_\_\_\_\_  
Please list all family members cared for in our office \_\_\_\_\_

## DENTAL INSURANCE

Company name \_\_\_\_\_  
Phone # \_\_\_\_\_ Group ID # \_\_\_\_\_  
Secondary coverage \_\_\_\_\_  
Phone # \_\_\_\_\_ Group ID # \_\_\_\_\_

## DENTAL / MEDICAL HISTORY

In case of an emergency, notify \_\_\_\_\_ Phone # \_\_\_\_\_  
Physician \_\_\_\_\_ Last physical \_\_\_\_\_ Phone # \_\_\_\_\_  
Pharmacy \_\_\_\_\_ Phone # \_\_\_\_\_  
Please list all medications presently taking \_\_\_\_\_  
Do you have allergies or adverse reactions to any medication? \_\_\_\_\_ Yes \_\_\_\_\_ No If so, please list all medications: \_\_\_\_\_  
Last dental visit \_\_\_\_\_ Have you had any previous dental treatment problems? \_\_\_\_\_

Do you have or have you had any of the following: please answer by putting an X by each question.

Heart Failure	Y	N	Glaucoma	Y	N	Pain in Jaw Joint	Y	N
Heart Disease	Y	N	Anemia	Y	N	Epilepsy, Seizures	Y	N
Heart Murmur	Y	N	Bleeding Problems	Y	N	Emphysema	Y	N
Congenital Heart Lesions	Y	N	Hemophilia	Y	N	Tuberculosis(TB)	Y	N
Angina Pectoris	Y	N	Kidney Trouble	Y	N	Asthma	Y	N
Artificial Heart Valve	Y	N	Hepatitis A(infectious)	Y	N	Sinus Trouble/Allergies	Y	N
Heart Pacemaker	Y	N	Hepatitis B(serum)	Y	N	Diabetes	Y	N
Heart Surgery	Y	N	Liver Disease	Y	N	HIV Positive	Y	N
High Blood Pressure	Y	N	Jaundice	Y	N	AIDS	Y	N
Rheumatic Fever	Y	N	Ulcers	Y	N	Venereal Disease	Y	N
Stroke	Y	N	Tumors/Growths	Y	N	Cold Sores, Fever Blisters	Y	N
Neurological Problems	Y	N	X-ray treatments	Y	N	Do you use tobacco	Y	N
Psychological Problems	Y	N	Cancer or Chemotherapy	Y	N	Do you drink alcohol	Y	N
Cortisone or Steroids	Y	N	Artificial Joints	Y	N	Are you pregnant	Y	N
Thyroid Disease	Y	N						

I hereby grant permission for dental treatment to be performed and will assume all responsibilities connected with such treatment. A broken appointment is a loss to everyone. **Please inform us 48 hours in advance if you are unable to keep your appointment. If you fail to do so, there will be a minimum charge of 50.00.**

Patient's (or Legal Guardian's) Signature \_\_\_\_\_ Date \_\_\_\_\_



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### EXAMINATION QUESTIONNAIRE

Name \_\_\_\_\_

How long has it been since you've had any of the following?

Dental exam \_\_\_\_\_ Dental x-rays \_\_\_\_\_ Professional cleaning \_\_\_\_\_

What prompted you to seek dental care at this time? \_\_\_\_\_

Are you satisfied with your past dental experiences? \_\_\_\_\_

Have you had your wisdom teeth removed? \_\_\_\_\_ Have you worn braces in the past? \_\_\_\_\_

Do you wear an appliance (retainer/night guard/snore guard/CPAP)? \_\_\_\_\_

How often do you usually perform any of the following?

Brush \_\_\_\_\_ Floss \_\_\_\_\_ Professional cleaning \_\_\_\_\_

Please check any of the following that pertain to you:

Bleeding gums	Crooked teeth	Hot/Cold Sensitivity	Snoring
Chewing sensitivity	Discoloration	Joint discomfort	Tender gums
Clenching/Grinding	Fatigue	Poor sleep	Throbbing pain
Congestion	Frequent headaches	Seasonal allergies	

If you circled any of the above items, please explain. \_\_\_\_\_

Is there anything you would like to change about the appearance of your \_\_\_\_\_

smile? Please check any of the following areas of interest:

Whitening	Invisalign	Crowns	Snore Guard
Bonding	Cosmetic Dentistry	Veneers	Night Guard

On a scale of 1-10, 10 being very important, how important are your teeth? \_\_\_\_\_

Whom may we thank for your referral? \_\_\_\_\_

I do[ ]/do not[ ]give my permission to use photos of my smile, teeth, and gums in any marketing including, but not limited to website publication, Facebook, print advertisements, newspapers, magazines, electronic media, phonebooks, brochures, fliers and presentations.

Signature \_\_\_\_\_

Date \_\_\_\_\_



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### FINANCIAL/INSURANCE INFORMATION

Full name of policy holder: \_\_\_\_\_

Social Security # of policy holder: \_\_\_\_\_

Date of birth of policy holder: \_\_\_\_\_

Dental insurance company name and mailing address:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone#: \_\_\_\_\_ Group ID#: \_\_\_\_\_

We will do our best to estimate what each insurance company will cover. Keep in mind we are not a preferred provider on any plan. Please note it is only an estimate and the patient will be responsible for the entire remaining balance for themselves and/or their dependent(s) at time of treatment.

#### We have several payment options:

- If treatment is paid in full with cash or check a 5% **courtesy** will be extended. Any insurance reimbursements will be paid directly to the patient. (Applies only to treatment over \$1000).
- Payments may be made in full by Visa, Master Card, and American Express.
- Flexible monthly payments available with **Care Credit**.
- **3 equal payments** with post dated check or with credit card number (1/3 down at start of treatment) for treatment over \$1000.
- **If insurance payments are not received 45 days after treatment the patient will be asked to pay in full.**
- As a courtesy, **we will file your insurance** after an estimated patient portion is paid however, to file your insurance we must have a credit card on file.

I hereby grant permission for dental treatment to be performed and will assume all responsibilities connected with such treatment.

Patient's (or Legal Guardian's) Signature \_\_\_\_\_

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



ASHLY COTHERN DDS

# Pre-Authorized Health Care Form

I authorize **Ashly Cothern DDS** to keep my signature on file and to charge my credit/debit account for the balance of charges not paid by insurance within 60 days.

I understand that this form is valid unless I cancel the authorization through written notice to the health provider.

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

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

Cardholder Address: \_\_\_\_\_

City: \_\_\_\_\_

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

Cell Phone #: \_\_\_\_\_

Card of Choice: MC \_\_\_\_\_ Visa \_\_\_\_\_ Amex \_\_\_\_\_ Discover \_\_\_\_\_ HCFP \_\_\_\_\_

Account Number: \_\_\_\_\_

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

Security Code: \_\_\_\_\_

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

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

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Due to the **Health Insurance Portability and Accountability Act**, our privacy policy is now available to our patients. It informs you how we use and disclose your health information for treatment, payment, and healthcare operations. This will be done at the patient's request. A copy of our policy will be available in the office waiting room for patient's review. Your signature is your acknowledgement of this HIPAA policy.

**Patient signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have a right to read our *Notice of Privacy Practices* before you decide whether to sign this consent. You will have the right to revoke this consent at any time by giving us written notice of your revocation by certified mail.

I, \_\_\_\_\_, have had the opportunity to read and consider the contents of this consent form and Dr. Ashly Cothern's *Notice of Privacy Practices*. I understand that by signing this form, I am giving my consent to Dr. Ashly Cothern's use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

**Patient signature** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Thank you for your cooperation in complying with the Federal HIPAA Regulations. This privacy of your health information is important to us. At your request, we will be happy to provide you with a copy of this consent form.**