LEATHERWOOD
Family & Cosmetic Dentistry

Confidential Patient Information

Patient Name: _____

DOB: _____ Social Security No.: _____

Home Address: _____ City/State: _____ Zip: _____

Cell Phone: _____ ***Text OK? Yes or No*** (Other) Phone: _____

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Whom may we thank for this referral: _____

Insurance Information

Insured's Name: _____ Insured's Birthdate: _____

Relationship to Patient: _____ is the insured a current patient? **Yes/No**

Social Security No.: _____ Employer: _____

Insurance Company: _____ Provider Phone: _____

Subscriber ID#:_____ Group Name: _____ Group No.: _____

Claim's Mailing Address: _____ City/State/Zip: _____

Person Responsible for the Account: _____

Consent for Services

I hereby authorize Leatherwood Family & Cosmetic Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate. I also authorize Dr. Samantha Leatherwood to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I grant my permission to Leatherwood Family & Cosmetic Dentistry to leave messages via telephone, email, or text regarding future appointments. I am aware that Leatherwood Family & Cosmetic Dentistry follows HIPAA's privacy practices.

I understand that it is the policy of this office to require at least ***48 hours advance notice*** for any cancellation or scheduling changes.

_____

Signature Printed Name Date

MEDICAL HISTORY

Are you currently under the care of a Physician: _____ Date of Last Exam: _____

Physician's Name/Phone #: _____Specialty:_____

Please rate your opinion of your general health (circle one): Excellent Good Fair Poor

Please list current medications and supplements:

Drug _____Dosage _____Reason _____

Drug _____Dosage _____Reason _____

Drug _____Dosage _____Reason _____

Has a physician recommended you to take premedication before dental appointments? **Yes** **No**

Women Only:

Are you pregnant or do you think you may be pregnant? Yes No

Are you nursing? Yes No Are you taking birth control pills? Yes No

Do you have or have you had any of the following (Circle all that apply):

Acid Reflux/GERD	Cirrhosis	Heart Stents	Mitral Valve Prolapse
ADD/ADHD	Cold Sores	Hemophilia	Multiple Sclerosis
AIDS/HIV	COPD	Hepatitis A/B/C	Radiation Therapy
Anemia	Depression	High Blood Pressure	Respiratory Problems
Angina	Diabetes	High Cholesterol	Rheumatic Fever
Anxiety	Emphysema	High Thyroid	Seasonal Allergies
Arthritis	Epilepsy/Seizures	History of Cancer	Sexually Transmitted Disease
Artificial Heart Valve	Glaucoma	Human Papilloma Virus	Sleep Apnea
Asthma	Heart Arrhythmia	Joint Replacement	Sinus Troubles
Autism	Heart Attack	Kidney Disease	Stomach Troubles/Ulcers
Autoimmune Disorder	Heart Disease	Liver Disease	Stroke
Cardiac Pacemaker	Heart Murmur	Low Blood Pressure	Tension Headaches
	Heart Pacemaker	Low Thyroid	

Do you have any conditions or diagnoses that are not listed? _____

Allergies or had any reaction to the following (Check all that apply):

Acetaminophen	Clindamycin	Latex	Sulfa
Aspirin	Codeine	Local Anesthetics	Tramadol
Azithromycin	Ibuprofen	Penicillin	Other(s): _____

_____

Signature Printed Name Date

_____

Doctor Signature Date

DENTAL HISTORY

I rate my overall dental health as (circle one): Excellent Good Fair Poor

What would need to be done to rate it Excellent? _____

Are you having any pain at this time (please explain)? _____

I prefer to approach my oral health (circle one):

Proactively to prevent pain, major complications and keep my natural teeth.

Reactively and only treat issues when there is pain or other noticeable changes.

Unsure…I have certain budget of time and money that I am willing to spend on my oral health.

I routinely see the dentist (circle one): 3 mos 4 mos 6 mos 12 mos Not routinely

Date of last dental visit? _____ Date of last x-rays? _____

Do you have any anxiety about dental treatment?	**YES**	**NO**
Are you interested in Sedation Dentistry?	**YES**	**NO**
Do you have previous dental restorations over 10 years old?	**YES**	**NO**
Do you have any jaw soreness or joint sound (clicking/popping)?	**YES**	**NO**
Does your jaw ever lock open or closed?	**YES**	**NO**
Do you grind or clinch you teeth?	**YES**	**NO**
Do you have any missing teeth that you would like to replace?	**YES**	**NO**

Do you have sensitivity to (please circle all that apply):

Cold **Heat** **Sweets** **None**

Did you know Periodontal Disease is painless and it affects 87% of the adult population? Periodontal Disease increases the risk of heart attack and stroke left untreated. There are warning signs:

Do your gums bleed with brushing or flossing?	**YES**	**NO**
Are your gums red, swollen or tender?	**YES**	**NO**
Have you ever been told you needed a "Deep Clean"?	**YES**	**NO**
Have your gums ever been numbed before a cleaning?	**YES**	**NO**
Have you noticed your teeth shifting or had bite changes?	**YES**	**NO**
Are your gums drifting away from the teeth?	**YES**	**NO**

_____

Signature Printed Name Date

_____

Doctor Signature Date

SMILE EVALUATION

How do you feel about the way your smile looks (circle one)?

I LOVE MY SMILE! **I DON'T LIKE MY SMILE**

MY SMILE IS OK **I HATE MY SMILE…HELP!**

Have you stopped smiling because of the appearance of your teeth?	**YES**	**NO**
Have you been disappointed with the appearance of previous dental work?	**YES**	**NO**
Do you have dark lines around existing crowns?	**YES**	**NO**
Do you have metal (mercury based) fillings showing?	**YES**	**NO**

If you could change anything about your smile, what would it be?

_____

_____

_____

LEATHERWOOD WAY

Have you thought about how it would feel to have a smile you deserve?...Everyone deserves a healthy beautiful smile!

All patients get a comprehensive treatment plan that not only addresses urgent needs, but also gives you the opportunity to achieve pristine oral health. My obligation is to present patients with all of your options without judgment.

Research over the past 15 years has linked Heart Attack, Stroke, Dementia, Alzheimer Disease, Autoimmune Disorders and other conditions to untreated periodontal disease and sepsis from leaking/failing old dentistry and decay. The bacteria responsible for cavities and Periodontal Disease invades the vasculature of the mouth and contaminates the blood stream causing sepsis. This also causes inflammation that travels down the vessels of the body and can cause plaques to dislodge and travel to smaller vessels and stop the blood flow.

My job is to get you to optimal oral health by providing solutions to improve biology, function and esthetics. This will reduce your risk of systemic disease, help you function comfortably and give you a smile that will last a lifetime. Your job is to let me know if you are interested in it and how fast or how slow you would like to go to achieve this goal.

I really appreciate the opportunity to care for you and look forward to working together to help you achieve your goals!

Samantha Leatherwood, DMD

_____

Signature Printed Name Date

_____

Doctor Signature Date

TREATMENT CONSENT AND FINANCIAL POLICY

I hereby authorize Leatherwood Family & Cosmetic Dentistry to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate and also authorize Dr. Samantha Leatherwood to prescribe any and all forms of medication, and perform any therapy that may be indicated and agreed upon.

I understand that by consenting to treatment recommended by Dr. Samantha Leatherwood, I am complying with her standard of care for my dental health. The standard of care set forth by my insurance company sometimes will not coincide with Dr. Leatherwood's standard of care. Therefore, any charges not covered by insurance with regard to my dental treatment at Leatherwood Family & Cosmetic Dentistry are my responsibilities this will include but is not limited to:

- **Exams**
- **Radiographs / Xrays necessary to diagnose dental disease and to remain compliant with the Texas State Dental Board of Examiners**
- **Teeth cleanings and periodontal therapy**

We are committed to providing you the best possible care available, regardless of the limitations insurance places on treatment. Our office is an out-of-network provider and we will file dental claims as a courtesy. Our commitment is to you, our patient, not to an insurance company.

If your insurance company has not paid all remaining charges within 45 days of treatment, you will become responsible for the entire account balance. Insurance follow-up and reimbursement attempts also becomes your responsibility. We offer several options regarding financial agreements for your treatment.

We appreciate your cooperation in this matter. This will allow us to stay focused on our mission of achieving your oral health goals.

Thank You,

Samantha Leatherwood, DMD

_____

Signature Printed Name Date

Patient HIPAA Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that this office comply with certain rules regarding the maintenance of the privacy of your information we have collected and will collect in the future.

To comply with one of HIPAA's requirements we are giving you a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices.

From time to time it may be necessary for us to make disclosures of your information in connection with our treatment. For example, we may make a referral to or consult with another dentist or other health care professional, provide a specimen to a laboratory for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgement
Please sign this form below to acknowledge that you have today received or been offered a copy of our notice of privacy practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

Signature **Printed Name** **Date**

I am also signing for my minor children:

Patient Consent
Please sign this form below to consent to our disclosures of your information that we deem necessary in order to provide proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment. I understand that such disclosures may not be of the type listed above.

Signature **Printed Name** **Date**

I am also signing for my minor children:

I also give consent for my treatment to be discussed with the following individuals: (e.g. spouse, parent, adult child, care giver)

For office use only
Patient refused to sign.

The following circumstances prohibited the patient from signing the Acknowledgement:

An emergency situation prevented the patient (parent/guardian) from signing the Acknowledgement.

Office Personnel (signature) Office Personnel (print name) Date