Welcome!

DENTISTRY

Patient Information

Patient Name: _____ (Last / First / Middle Initial) Preferred Name: _____

Street Address: _____ (Street / City / State / Zip)

If student, permanent address: _____

Date of Birth: ____/____/_____ Driver's License No. _____

Employer:_____Social Security #: _____-_____-_____

Home Phone: _____ Work Phone: _____ Ext: _____

Other: _____ Cell Phone: _____

Email Address:_____

Would you like us to send you an email or text message to remind you of your appointments?

Yes ☐ No ☐ If not we will call you the day before to confirm your appointment.

Please consider other patients and give at least 24 hours notice to change your appointment.

Spouse/Guardian Name: _____

Spouse's Employer: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Person to contact in case of emergency: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

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

Insurance Information

Please note we are not a participating provider for any insurance network.

Primary Dental Insurance: _____ Phone:_____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/_____

Subscriber's SS# or ID#: _____/_____/_____ Group#: _____

Secondary Dental Insurance: _____ Phone: _____

Subscriber's Name: _____ Subscriber's Date of Birth: ____/____/_____

Subscriber's SS# or ID#: _____/_____/_____ Group#: _____

J. Craig Scasta, D.D.S.
Robert A. Hall, D.D.S.

Patient Name: _____

Date: _____

Medical History

Thank you for selecting our team! We will strive to provide you with the best possible care. To help us meet your dental needs, please answer the following questions.

What is the approximate date of your last doctor's visit? ___/____/_____

If you have a physician or family doctor, what is his/her phone number? _____

How do you rate your current physical health? ☐ Good ☐ Fair ☐ Poor

Are you under medical treatment now? ☐ Yes ☐ No If yes, please describe: _____

_____

Have you been hospitalized for any surgical operation or serious illness within the last 5 years? ☐ Yes ☐ No

If yes, please describe: _____

Current medications (including OTC): _____

Do you have a persistent cough or throat clearing not associated with a known illness, lasting more than 3 weeks? ☐ Yes ☐ No

The following health conditions have a direct effect on your dental care. Please answer completely. Do you have or have you ever had any of the following:

☐ Mitral valve prolapse ☐ Heart murmur ☐ Joint replacement ☐ Rheumatic Fever

☐ Cardiac myopathy ☐ Diabetes ☐ No

Have you ever been required to take antibiotics prior to dental appointment? ☑ Yes ☑ No

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

☐ High blood pressure	☐ Low blood pressure	☐ Heart attack	☐ Heart disease
☐ Pacemaker	☐ Angina	☐ Chest pains	☐ Stroke
☐ Arthritis	☐ Swollen Ankles	☐ Respiratory problems	☐ Asthma
☐ Hay fever/allergies	☐ Thyroid problems	☐ Kidney disease	☐ Liver disease
☐ Fainting/Seizures	☐ Hemophilia	☐ Epilepsy/Convulsions	☐ Easily winded
☐ Frequently tired	☐ AIDS or HIV	☐ Leukemia	☐ Anemia
☐ Emphysema	☐ Cancer	☐ Chemotherapy	☐ Glaucoma
☐ Hepatitis/Jaundice	☐ Tuberculosis	☐ Recent weight loss	☐ Sleep Apnea
☐ Tonsillectomy	☐ Insomnia	☐ Adenoectomy	☐ Restless Leg Syndrome (RLS)
☐ Radiation therapy	☐ Fibromyalgia	☐ Stomach troubles/Ulcers, Colitis	
☐ Other			

Do you wear contact lenses? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Are you allergic to or have you had any reactions to the following?

☐ Local anesthetics ☐ Sedatives, dental anesthetic ☐ Penicillin ☐ Aspirin

☐ Erythromycin ☐ Tetracycline ☐ Codeine ☐ Sulfa drugs

☐ Barbiturates ☐ Iodine ☐ Any metals (nickel, mercury, etc)

☐ Latex rubber ☐ No known allergies ☐ Other, please list_____

_____

Do you have or experience any of the following :

tired jaws, especially in the morning ☐ Yes ☐ No ☐ Sometimes

frequent headaches ☐ Yes ☐ No ☐ Sometimes

Snoring ☐ Yes ☐ No ☐ Sometimes

Daytime sleepiness ☐ Yes ☐ No ☐ Sometimes

wake up repeatedly during the night ☐ Yes ☐ No ☐ Sometimes

difficulty breathing through your nose ☐ Yes ☐ No ☐ Sometimes

Do you have difficulty breathing through your nose ☐ Yes ☐ No ☐ Sometimes

Are you taking any sleep medications? ☐ NO ☐ Ambien ☐ Lunestra Other: _____

Are you aware of breathing through your mouth during the day or at night? ☐ Yes ☐ No

Have you had a sleep study? ☐ Yes ☐ No

Have you ever been prescribed a CPAP? ☐ Yes ☐ No

If you wear a CPAP, how often do you wear it? ☐ Always ☐ Sometimes ☐ Never

Women only:

Are you taking oral contraceptives (birth control pills)? ☐ Yes ☐ No

Are you pregnant or think you may be pregnant? ☐ Yes ☐ No ☐ Not applicable

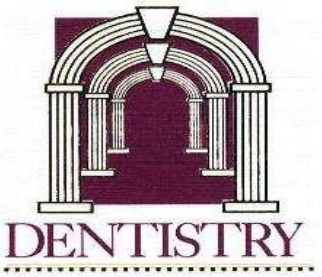
If you are pregnant, how many weeks? _____Are you nursing? ☐ Yes ☐ No ☐ Not applicable

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(if child under 18)



J. Craig Scasta, D.D.S.
Robert A. Hall, D.D.S.

Dental History

Patient Name_____

What is the reason for your visit today?

☐ Checkup ☐ Toothache ☐ TMJ evaluation ☐ Teeth or gums hurting / bothering me

☐ Other ☐ Sleep evaluation

Have you ever used nitrous oxide? ☐ Yes ☐ No If yes, did you like it? ☐ Yes ☐ No

When was the last time you were seen by a dentist for :

teeth cleaning? _____/_____/_____ complete dental exam? _____/_____/_____

How often do you have dental examinations? ☐ Twice a year ☐ Once per year ☐ First visit

☐ Once per two years ☐ Once per three years ☐ More than three years in between

How many times a day do you :

Brush your teeth _____ Floss _____ Rinse your teeth _____

What type of toothbrush do you use? ☐ Manual ☐ Electric ☐ Both

Do you wear dentures or partial? ☐ Yes ☐ No If yes, when were they placed? _____/_____/_____

Are you using any other dental devices? ☐ Yes ☐ No If yes, please describe: _____

Do you have any dental problems now or feel pain to any of your teeth? ☐ Yes ☐ No

If yes, please describe: _____

Are your teeth sensitive to any of the following? ☐ Hot ☐ Cold ☐ Sweets ☐ Biting or Chewing

Do you have or are experiencing any of the following:

any sores or lumps in or near your mouth	☐ Yes	☐ No	☐ Sometimes
gums bleed while brushing	☐ Yes	☐ No	☐ Sometimes
food caught in between your teeth	☐ Yes	☐ No	☐ Sometimes
clench or grind your teeth	☐ Yes	☐ No	☐ Sometimes
bite your lips or cheeks frequently	☐ Yes	☐ No	☐ Sometimes

Do you hold foreign objects with your teeth (pencils, pipe, pens, nails, etc.)? ☐ Yes ☐ No ☐ Sometimes

Do you smoke or use tobacco? ☐ Yes ☐ No ☐ Sometimes

Have you ever had any history of orthodontic treatment (for example: braces, retainer, etc)? ☐ Yes ☐ No

If yes, when was treatment completed? _____/_____/_____

Have you ever had any of the following?

☐ Oral surgery ☐ Periodontal treatment ☐ Gum therapy ☐ teeth ground or bite adjusted

☐ A bite plate / mouthguard ☐ A serious injury to the mouth or head

Have you ever experienced any of the following:

☐ Clicking / popping of the jaw ☐ Pain in joint, ear, side of face ☐ Difficulty in opening / closing of the mouth ☐ Difficulty in chewing on either side of the mouth ☐ Headaches, neckaches or shoulder aches

Have you ever had any difficult tooth extractions in the past? ☐ Yes ☐ No ☐ Don't remember

Have you ever had any prolonged bleeding following tooth extractions? ☐ Yes ☐ No ☐ Don't remember

Have you ever received oral hygiene instructions regarding the care of your teeth and gums? ☐ Yes ☐ No

Are you interested in doing cosmetic treatment (whitening, straightening teeth, changing smile)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe: _____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

(if child under 18)

J. Craig Scasta, D.D.S and Robert A. Hall, D.D.S
1615 Barak Lane Suite 2, Bryan, TX 77802
Phone: (979)260-2626
Fax: (979)260-2631

FINANCIAL POLICY

GENERAL
Thank you for choosing our practice your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of out Financial Policy, which we require you to read, and sign prior to treatment. All patients must complete Patient Information and Insurance form before seeing the doctor. PAYMENT IS DUE AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, AND CARECREDIT.

DENTAL INSURANCE
Dental insurance is intended to cover some, but not all, of the cost of your dental care. Most insurance include a deductible and other expenses that are the responsibility of the patient. We will assist you in filing your insurance. If you have insurance, please bring your card with you to assure that we will be able to **estimate** your benefits. If you insurance has not paid within sixty (60) days from the date of service you will be mailed a statement if any balance is remaining on your account. It will be your responsibility to promptly pay the balance in full to avoid incurring finance charges. **We are not contracted with any insurance companies, therefore we will be considered OUT OF NETWORK.**

USUAL AND CUSTOMARY RATES
Our practice is committed in providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MEDICAL INSURANCE
Medical insurance is intended to cover some, but not all, of the cost for services rendered. Most insurance policies include deductible and other expenses that are the responsibility of the patient. Some procedures are not covered or require preauthorization. We will assist you in filing your medical insurance. **We do not accept assignment of benefits on medical claims; therefore payment in full is due at time of service. We are not contracted with any insurance companies, therefore we will be considered OUT OF NETWORK. We are not a Medicare or Medicaid provider therefore we are not allowed to file Medicare or Medicaid.**

ADULT PATIENTS
Adult patients are responsible for full payment at time service or estimated portion it patient is insured.

MINOR PATIENTS
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.

MISSED APPOINTMENTS
Please consider other patients and give at least 24 hours notice to change your appointment. This allows us to better utilize our time for all patients. We reserve the right to charge a $30 missed appointment fee should missed appointments become excessive.

INTEREST
We reserve the right to charge interest in the amount of %18 per annum as provided by state law.

Thank your for understanding the Financial Policy

Patient (Guardian) signature: _____

PATIENT RECORDS REQUEST FORM

J. Craig Scasta, DDS, PA
Robert A Hall, DDS, Inc.
1615 Barak Lane
Bryan, TX 77802
Ph: 979-260-2626 / Fax: 979-260.2631

This form entitles our office to request any necessary records from previous dentist, and or physicians if needed.

Name of Patient Whose Record is Requested_____

DOB_____ Phone_____

Address _____ City/State/Zip_____-----_____

Please provide a copy of the record as indicated below:

☐ The full health record maintained by this provider/practice

☐ The health record for the following time frame: _____ through _____

☐ A specific section of the health record as described below:

_____

_____

_____

☐ A summary of the information requested above is adequate to fulfill this request.

☐ As permitted by federal and state law, I understand that a fee of _____ cents per page will be charged for copying the records along with a clerical fee of _____. In addition, a fee of _____ will be charged for any duplication of x-rays. I agree to pay this charge in full at the time I receive the copy of the record.

Signature of Patient _____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date_____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

J. Craig Scasta, DDS, PA
Robert A Hall, DDS, Inc.
1615 Barak Lane, Suite #2
Bryan, TX 77802
979-260-2626

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly

Obtain payment from third-party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ______________________________ Date: ______________________

Signature: ________________________________

Relationship to Patient: ______________________

Dependent family members also covered by this acknowledgement:

____

____

- -

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

Submit form