Patient Information

Patient's Name: _____ Today's Date: _____

Home Address _____

City_____ Zip_____ Res. Tel.#_____ Cell# _____

Social Security # ____-____-____ Date of Birth ____/____/____ Age_____ Marital Status S/M/D/W

Your Occupation_____ Employer_____ Bus.Tel# _____

Spouse's Name_____ Social Security # ____-____-____

Your spouse's Occupation_____ Employer_____ Bus.Tel# _____

Person to contact in an emergency_____ Relation_____

Res. Tel. #_____ Bus. Tel. #_____ Address_____

Party responsible for account _____ Bus Tel. #_____ Res Tel.#_____

Email address: _____

Reason for this visit _____

Whom may we thank for referring you?_____

DENTAL HEALTH HISTORY

For your safety and to assist us in accurately diagnosing and treating you, please carefully review this form completely and fill out all areas which pertain to you. ALL INFORMATION IS KEPT CONFIDENTIAL

Dental History:

Previous Dentist_____ City_____ How long_____

Date of last visit_____ Date of last dental cleaning_____ Date of last full mouth x-ray _____

1. Why did you leave your last dentist?_____
2. What did you like most about any dentist, or a dental office you have been to?_____
3. What did you like least about any dentist, or dental office that you have been to?_____

Check any of the following you have had or currently have:

___ Orthodontic Treatment
___ Have Lightened Your Teeth Before
___ Grind or Clench your teeth (Daytime or Nighttime)
___ Pain, Clicking, Popping in Jaw Joints
___ Awake with Sore Jaws
___ Periodontal Treatment
___ Gum Abscesses
___ Gums Bleed when Brushing
___ Mouth Odor or Bad Taste
___ Bruise Easily
___ Loose, Shifting or missing Teeth
___ Trouble Chewing/Speaking
___ Fear of Dental Treatment
___ Immediate Relatives that have lost all of their Natural Teeth
___ Complications with or following previous Dental or Oral Surgical treatment
___ Sensitive Teeth (Hot, Cold, Sweets)
___ Cold Sores or Fever Blisters
___ Bridges, Partials or Dentures

f you could change one thing about your smile, what would that be?_____

_____

f there was a simple, inexpensive way to whiten your teeth, would you be interested? Y N

)o you want to keep your teeth? ____ Yes, no matter how much trouble
____ Yes, if it's not too much trouble
____ I don't know
____ I don't care

Patient Health History

Medical Health History:

1. Describe your present health___ Excellent ___ Good ___ Fair ___ Poor Height ____ Weight _____
2. List your current Physician(s): a._____ Type_____
   b._____ Type_____
3. Date of your last physical exam _____/_____/_____ Purpose_____
4. Are you aware of any changes in your general health in the last year? No Yes _____
5. Have you been hospitalized for illness or surgery in the past two years? No Yes _____
6. Have you been under a medical doctor's care during the past two years? No Yes _____
7. Have you ever had excessive bleeding that required special treatment? No Yes _____
8. Is there any history of diabetes in your family? No Yes _____
9. Are you on a special or restricted diet of any kind? No Yes _____
10. Do you smoke? ___ No ___ Yes How much?_____ How long? _____
11. Do you consume drinks with caffeine? ___ No ___ Yes How many?_____
12. Do you consume alcoholic drinks? ___ No ___ Yes How many drinks per day _____ per week_____
13. Are you taking blood thinners including aspirin? ___ No ___ Yes
13. List all medications you are now taking (include over the counter)_____

_____

List all medications you are allergic to: _____

Indicate which of the following you have had or presently have, circle yes or no:

A Nervous Person	No/Yes	Epilepsy or Seizures	No/Yes	Liver Disease	No/Yes
AIDS	No/Yes	Fainting or Dizzy Spells	No/Yes	Low Blood Pressure	No/Yes
Allergies or Hives	No/Yes	Frequent Headaches	No/Yes	Persistent Cough	No/Yes
Anemia	No/Yes	Frequent Thirst/Urination	No/Yes	Psychiatric Care	No/Yes
Angina	No/Yes	Glaucoma	No/Yes	Radiation Treatment	No/Yes
*Arthritis Rheumatism	No/Yes	Hay Fever	No/Yes	Rheumatic Fever	No/Yes
*Artificial Joint (Knee, Hip)	No/Yes	Heart Disease or Attack	No/Yes	Scarlet Fever	No/Yes
*Artificial Heart Valve	No/Yes	Heart Murmur	No/Yes	Shortness of Breath	No/Yes
Asthma	No/Yes	Heart Pacemakers	No/Yes	Sinus Trouble	No/Yes
Blood Transfusions	No/Yes	Heart Surgery	No/Yes	Stroke	No/Yes
Birth control pills	No/Yes	Heart Trouble	No/Yes	Taking hormone med.	No/Yes
Cancers or Tumors	No/Yes	Hemophilia	No/Yes	Thyroid Disease	No/Yes
Chemotherapy	No/Yes	Hepatitis	No/Yes	Tuberculosis	No/Yes
Congenital Heart Lesions	No/Yes	High Blood Pressure	No/Yes	Ulcers	No/Yes
Diabetes	No/Yes	HIV Positive	No/Yes	Weight Loss/Gain	No/Yes
Drug/Alcohol Addict	No/Yes	If female, are you pregnant?	No/Yes		
Emphysema	No/Yes	Kidney or Bladder Trouble	No/Yes		

*** If yes to any of starred conditions please call prior to appointment.**

Do you have any medical conditions or diseases we should know about? No/Yes

Explain: _____

To the best of my knowledge, all the preceding answers are true and correct. If I have any changes in my health or medicines, I will inform the Doctor on or before my next appointment, without fail.

Patient's Signature: _____ Date: _____

Doctor's Signature: _____ Date: _____

Michael Masera, DDS
9660 Hillcroft, Suite 110
Houston, TX 77096
713-723-5615

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

NAME OF PATIENT OR INDIVIDUAL

Last _____ First _____ Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS: _____

I AUTHORIZE THE FOLLOWING T O DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION: For the purpose of billing, claims and supportive information.

Insurance Company Name _____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?
Person/Family Member/Friend/Significant Other _____

Phone (_____)_____ Email _____

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

☐ **All health information** ☐ History/Physical Exam ☐ Past/Present Medications ☐ Lab Results
☐ Physician's Orders ☐ Patient Allergies ☐ Consultation Reports ☐ Progress Notes ☐ Diagnostic Test Reports
☐ Pathology Reports ☐ Billing Information ☐ Radiology Images ☐ Other_____

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day _____ Year _____

RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health/dental information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

SIGNATURE X_____ _____
Signature of Individual or Individual's Legally Authorized Representative DATE

Printed Name of Legally Authorized Representative (if applicable): _____

If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

2024

Michael Masera, DDS.
9660 Hilcroft, Suite 110
Houston, TX 77096
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Insurance Information, Assignment and Release

As many of you know throughout the years insurance benefits have changed. The New Year started and there will probably be more changes this year. We do not always know what these changes will be until the insurance companies start processing the claims. We will do our best to help you understand your benefits, but we ask our patients to please read their insurance benefit booklet, so you can stay on top of any existing and new information.

There are hundreds of PPO insurance companies, and it is impossible to belong to all of them. We do, however, feel we are very competitive (fair) with our office fee schedule. We try to remain in the average range for our area, when it comes to fees.

There are certain guidelines that should be outlines in your benefits booklet, such as, how many cleanings and exams you may have in one year, what your deductible and maximum is and basic inclusions and exclusions. If you have been to another office and have used part of your dental maximum, this will affect the amount of benefit you have remaining to use in our office. If you have college age children, you may need to send proof of student status to your insurance company to have your child be eligible for benefits. We do our best to be as accurate as we can, but the ultimate responsibility is with the Subscriber (patient/parent) to pay whatever your insurance company does not pay in our office. If the insurance company does not pay the estimated amount to our office you will be responsible to pay the balance of your account within 30 days.

I certify that I and my dependent have insurance coverage with _____ and I am assigning the benefits directly to Dr.Masera I know I am financially responsible for any balance not paid by my insurance company for me or my dependent(s). I understand that Dr. Masera's office is giving me an estimation of the amount my insurance company will assist me (my family) with for necessary services, but I do not hold them responsible in the event that my insurance company does not reimburse the benefit as expected.

This consent is valid for one year or until December 31, 2024, for me and any dependent(s).

Signature of Patient, Guardian or Personal Representative _____

Print Name of Patient, Guardian or Personal Representative _____

Relationship to patient _____

Date _____

Witness _____ Date _____

OralID

The 2 minute exam that can SAVE your life.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office fee for this procedure is $25.00 for the year.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

Signature Name Date