DNA DENTAL
DALLAS

MEDICAL HISTORY

DNA Dental Dallas, Dr. Darya Timin
6162 East Mockingbird Lane., Suite 205 Dallas, TX 75214
214-295-9270 | www.dnadentaldallas.com

Patient Name: ______________________________

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 have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.

Are you currently under the active care of a physician? If so, please list Doctor's Name and Phone number? ☐ Yes ☐ No
If Yes: Physician Name: ______________________ Phone Number: ______________________

Have you ever had a serious head or neck injury? ☐ Yes ☐ No
If Yes: ______________________________

Do you need to be pre-medicated with antibiotics for any heart or other conditions before dental treatment? ☐ Yes ☐ No
If Yes: ______________________________

List all prescription and over-the-counter medications or supplements you are currently taking:

____

Women Are You:
Pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No
If yes, which trimester? ☐ 1st ☐ 2nd ☐ 3rd

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa drugs ☐ LocalAnesthetic

Other: ☐ Yes ☐ No If Yes: ______________________________

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

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

Please list any serious illnesses not listed above: ______________________________

____

To the best of my knowledge, the questions on this form have been accurately answered. I understandthat providing incorrect information can be dangerous to my (or patent's) health.

Signature ______________________ Date ______________________

DENTAL HISTORY

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Patient Name: ______________________________

Please provide information on the last Dentist you have seen: ______________________________

Name: ______________________________

Phone Number: _____ ______________

Date Range Seen: ______________________________

Type of Treatment: ______________________________

What is the primary reason you came to our office today? ______________________________

Are you currently experiencing pain/discomfort? ☐ Yes ☐ No

Current dental health: ☐ Good ☐ Fair ☐ Poor

How often do you brush your teeth? __________ How often do you floss? __________

Do you use any other dental aids? (electric brushes, toothpick, floss threaders, etc) ______________________________

Are any of your teeth sensitive to: cold or hot? ☐ Yes ☐ No — sweet? ☐ Yes ☐ No — biting or chewing? ☐ Yes ☐ No

Are your gums red, puffy, bleed or hurt? ☐ Yes ☐ No

Does food catch between your teeth? ☐ Yes ☐ No

Have you ever experienced pain or discomfort in your jaw? ☐ Yes ☐ No

Do you have sore muscles in the neck or shoulders? ☐ Yes ☐ No

Do you clench or grind your teeth when you sleep or awake? ☐ Yes ☐ No

Do you have habits like chewing ice, holding/biting nails or pencils? ☐ Yes ☐ No

Do you snore during sleep? ☐ Yes ☐ No

Do you feel tired in the morning? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

What would you change about your smile? ______________________________

Do you have a "gummy" smile – showing too much gum tissue or having gums that are too thick? ☐ Yes ☐ No

Do you have any gray, black or silver (mercury) dental fillings in your teeth that you want to replace? ☐ Yes ☐ No

Do you have any old crowns that you don't like or that don't really look natural? ☐ Yes ☐ No

Do you smoke? ☐ Yes ☐ No, How much? __________

Do you feel nervous about dental treatment? If yes, what is you biggest concern? ______________________________

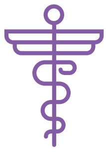
Have you had bad dental experience in past? ☐ Yes ☐ No

Explain: ______________________________

Tell us what you would like to learn more about:

☐ Orthodontics ☐ Cosmetic Dentistry ☐ Whitening ☐ Veneers ☐ Implants ☐ Dentures ☐ Other __________

Signature ______________________________ Date ______________________________



HIPAA CONSENT FORM

DNA Dental Dallas, Dr. Darya Timin
6162 East Mockingbird Lane., Suite 205
Dallas, TX 75214
(214)295-9270

www.dnadentaldallas.com

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

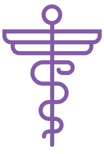
I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complex description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name: ____

Signature ______________________________ Date ______________________________



OFFICE POLICIES

DNA Dental Dallas, Dr. Darya Timin
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Cooperation

Successful dental treatment is a team effort involving you as the patient, the doctors and our team. Without cooperation, successful treatment planning, achieving optimal results and maintaining the treatment results are difficult or impossible and the results may be disappointing to everyone.
Cancellation and Broken Appointment Policy

• Reserved appointment time in any dental office is limited and valuable.
• It is extremely important that all patients honor their reserved dental appointments.
• Routine appointments require a 24-HOUR advance notice to reschedule.
• This will allow us time to offer your reserved appointment to someone who is waiting for an appointment or is in pain.
• In case of failure to give sufficient warning to keep a scheduled appointment (24 hours advance notification), will result in a $50.00 fee being charged. That charge which is in accordance with our dental office's broken appointment policy for all of out patients is to be paid within 30 days to prevent collection procedures. The patient/parent/legal guardian is responsible for the charge.

Financial Obligations

You have full responsibility for payment of the dental services that you or your dependents receive here. Fees are due and payable in full at or before the time services are rendered. A 1.5% finance charge (18% annually) will be added to any balance over 30 days past due. Any unpaid balance after 90 days will be sent to collections at which the patients responsive for any fees associated with the collection of the balance.

Regarding Insurance

Your insurance policy is a contract between you and your insurance company. We have no control over their decisions and the amount they pay. However, as a courtesy to our patients, we will file you primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and co-payments as accurately as possible. Please understands that all treatment plans given are only an estimate based on the information your insurance company provides. All deductibles and co-payments are due the day the treatment is rendered.

Please be aware that your insurance company does not guarantee payment over the phone. We will not know the exact amount they will pay until they respond to the claim. REGARDLESS OF WHAT YOUR INSURANCE COMPANY PAYS, YOU REMAIN FULLY RESPONSIBLE FOR PAYMENT OF YOUR BILL. Once a payment is received on your claim, we will send you a bill for any remaining balance on your account.

Maintenance Obligations

For successful treatment results and to lessen the risks of complication, you agree to comply with your individualized maintenance program and keep excellent home oral hygiene. It is typical to need follow-up visits for occlusal or other adjustments after treatment. You agree to notify the Practice at the soonest possible moment in the event that you experience pain, discomfort or any other problem that you believe may be related to treatment in our office. Nothing in this form extends the applicable statutes of repose or limitations for dental services. You agree to keep your follow-up appointments and to follow recommended treatments as well as follow other precautions and recommendations that may be provided as part of your pre-op or post-operative instructions.

By signing below, I acknowledge and agree to the terms above.

Signature ______________________________ Date ______________________________