



PATIENT & INSURANCE INFO

DNA DENTAL
DALLAS

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

Patient Information

Full Name: _____

I prefer to be called: _____

Birthdate: ___ / ___ / ___ Male Female

Address: _____

SS#: _____ Drivers lic: _____ E-mailAddress: _____

Home Number: (_____) _____ Cell/Other: (_____) _____

Where and when is the best way to reach you? _____

Single Married Divorced Widowed

Occupation: _____ Employer: _____

Employer's Address: _____

Work Number: (_____) _____ Ext. _____

Responsible Party (if someone other than the patient)

Full Name: _____

I prefer to be called: _____

Birthdate: ___ / ___ / ___ Male Female

Address: _____

SS#: _____ Drivers lic: _____ E-mailAddress: _____

Home Number: (_____) _____ Cell/Other: (_____) _____

Where and when is the best way to reach you? _____

In the event of an emergency, who should we contact? _____

Name: _____ Relation to you: _____

Work Number: (_____) _____ Home Number: (_____) _____ Cell Number: (_____) _____

Who referred you? _____

Primary Insurance Information

Name of Insured _____

Relationship to Insured: Self Spouse Child Other _____

Insured SS#: _____ Insured DOB: _____

Employer: _____

Address: _____

Ins. Company: _____

Address: _____

Customer Service Phone #: _____

Secondary Insurance Information _____

Name of Insured _____

Relationship to Insured: Self Spouse Child Other _____

Insured SS#: _____ Insured DOB: _____

Employer: _____

Address: _____

Ins. Company: _____

Address: _____

Customer Service Phone #: _____



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?

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

Please list any serious illnesses not listed above: _____

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

Signature _____ Date _____



DENTAL HISTORY

DNA Dental Dallas, Dr. Darya Timin
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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

D N A D E N T A L
D A L L A S

DNA Dental Dallas, Dr. Darya Timin
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Dallas, TX 75214
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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 _____



D N A D E N T A L
D A L L A S

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 our 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 responsible 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 your primary insurance claims for you.

Before treatment, we will verify your coverage and calculate your deductible and co-payments as accurately as possible. Please understand 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 _____