Favour Dental
5403 FM 1488 Suite A7
Magnolia, TX 77354

(281) 259-6717

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ SS# _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years

Home Phone _____ Cell Phone _____ Email _____

Employer _____ Employer Phone _____

Employer Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person
Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone _____

Birthdate _____ Currently a patient in our office? ☐ Yes ☐ No

Employer _____ Work Phone _____

E-Mail _____ Cell Phone _____

DENTAL INSURANCE INFORMATION

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL DENTAL INSURANCE

Name of Insured _____ Relation to Subscriber _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Subscriber ID _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Check (✓) if you have or have had problems with any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collecting Between the Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores or Growths in Mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name and Contact Number: _____ Date of last visit: _____

Pharmacy's Name and Address: _____ Pharmacy Contact #: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you ever had any serious illnesses or operations?? ☐ Yes ☐ No ***If yes, describe:*** _____

Are you Taking Blood Thinners? ☐ Yes ☐ No ***If yes: Type:*** _____ ***Dosage:*** _____

Do you have Artificial Heart Valves or Stents? ☐ Yes ☐ No ***If yes, When (Month and Year):*** _____

Do you have Artificial Joints or Replacements? ☐ Yes ☐ No ***If yes, When (Month and Year):*** _____

If Yes, what was replaced? _____ ***Metal / Mesh / Plastic*** ***Other:*** _____

(Women) Are you pregnant? ☐ Yes ☐ No ***If Yes, How many weeks/trimester?*** _____

Check (✓) if you have or have had problems with any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ **Artificial Heart Valves**
- ☐ **Artificial Joints, Pins, etc.**
- ☐ Asthma
- ☐ Bleeding Abnormally
- ☐ Blood Disease
- ☐ **Cancer**
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart lesions
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ **Heart Murmur**
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ **Hepititis**
- ☐ Hernia Repair
- ☐ High Blood Pressure
- ☐ **HIV/AIDS**
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ **Pacemaker**
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ **NONE**

List medications you are currently taking:

_____ _____

_____ _____

_____ _____

Allergies:

- ☐ Amoxicillin / Penicillin
- ☐ Aspirin
- ☐ Clindamycin
- ☐ Clove
- ☐ Codeine
- ☐ Iodine
- ☐ Latex
- ☐ Local Anesthetic:
  Type: _____
- ☐ Sulfa
- ☐ Other: _____
- ☐ **None**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my mindor child, ever have a change in health.

_____ _____

Signature of of Patient, Parent, Guardian or Personal Representative — Date

_____ _____

Please print name of Patient, Parent, Guardian or Personal Representative — Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

Favour Dental | Dr. Troy Bonin

5403 FM 1488 Suite A7 Magnolia, Texas 77354 | P: 281.259.6717 | F: 888.799.3076

Assignment of Benefits and Financial Agreement

Our office will accept an assignment of benefits from your insurance company with the following provisions. It is important to understand, though, that the contract regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for treatment, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

►Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort to maximize your insurance reimbursement. By having our office process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment.

►We require you to sign this form and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our office.

►Insurance payments ordinarily are received within 30-60 days from the time of billing. If your insurance company has not made payment to our office within 60 days, we will ask you to pay the balance due at that time. You will be responsible for seeking reimbursement from your insurance company at that time.

►Our office does not guarantee that your insurance company will pay for treatment you receive from our practice/ We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.

►Our office will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company.

Missed & Cancellations:

We may charge for all missed appointments **without** a 48 business hour notice given to the office. Treatment/Production appointment(s) may occur at rates of $50.00 for the first hour and $25.00 per every 30 mins thereafter per provider/per appointment.
A ***forty-eight (48) business hours*** notice is required to avoid all fees.
CANCELLATIONS CAN NOT BE ACCEPTED VIA EMAIL, TEXT, OR VOICEMAIL. WE ASK TO CONTACT OUR STAFF PERSONALLY TO AVOID FEES.

Charges & Payment:

All services rendered will be the responsibility of the patient. Payment(s) for services performed will be collected upon checking in, including any past due, or non-covered benefits by the insurance.

I HAVE READ AND UNDERSTAND THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO DR. BONIN, SMILES LLC. I HAVE READ THE ABOVE AND UNDERSTAND MY POSSIBLE FINANCIAL RESPONSIBILITY TO FAVOUR DENTAL AND HEREBY AFFIX MY SIGNATURE AS AN ACKNOWLEDGE OF THE UNDERSTANDING.

_____ _____

Signature of Patient, Parent or Guardian, or Legal Representative Date

Please Continue onto back →

Favour Dental | Dr. Troy Bonin

5403 FM 1488 Suite A7 Magnolia, Texas 77354 | P: 281.259.6717 | F: 888.799.3076

HIPAA OMNIBUS RULE

►PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims .

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Favour Dental. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS TO BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Patient Printed Name: _____

Additional Dependents under 18 : _____

_____

Signature (Patient / Legal Guardian): _____

►Please list any other parties who are actively involved in your health care and who can have access to your health information. (This includes step parents, grandparents and any caretakers who can have access to this patient's records.)

_____

Name & Relation *Name & Relation*

_____

Name & Relation *Name & Relation*

►I authorize contact from this office to CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA:

☐ Cell Phone, Email, Text, and Home ☐ Work Phone ☐ I do not give my consent

►I authorize INFORMATION ABOUT MY HEALTH to be conveyed via:

☐ Cell Phone, Email, Text, and Home ☐ Work Phone ☐ I do not give my consent

---

Authorization to Release Healthcare Information

I authorize this form to stand as my consent per my verbal request for information about my health when indicated to the listed email below.
This Authorization Expires 1 (one) year after the signed date.
IE: X-Rays, Account Prints, School/Work Note, Referral Letters by Dr. Bonin

Email: _____@ _____.COM
(Please print clearly)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize Favour Dental to recommend products or services to promote your improved health. Favour Dental may or may not receive third party remuneration from these affiliated companies. We, under the current HIPAA Omnibus Rule, provide you this information with your knowledge and consent. In signing you are authorizing consent to email per listed above upon your request.

Signature (Patient / Legal Guardian): _____

OFFICE USE ONLY

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

☐ It was emergency treatment ☐ The patient refused to sign because _____
☐ I could not communicate with the patient ☐ Other (please describe) _____
Signature of Privacy Officer _____ _____

Revision 01/2023