TEXAS SAGE DENTISTRY
400 North Tennessee Street
McKinney, Texas 75069

TEXAS SAGE
DENTISTRY

Dr. Barret Davidson, D.D.S.
Dr. Eugene Dahl, D.D.S., P.C.

Patient Information — PLEASE PRINT CLEARLY

Legal First and Last Name _____

Home Address _____

City State Zip

Cell Phone # _____ Home/Other Phone # _____

E-mail Address _____ Preferred method of contact _____

Best time of day to be reached _____ Referred by _____

Birthdate _____ Gender _____ Marital Status _____

Social Security # _____ Drivers License # _____ State _____

Employer _____ City _____ State _____

In Case of an Emergency, who should we contact? _____

Relationship _____ Phone Number _____

Who is responsible for payment? _____ Relationship to patient? _____

In your own words, briefly describe the reasons and related conditions for this visit. _____

_____

_____

May we take x-rays as needed for treatment? YES NO

What end result(s) do you hope to achieve through treatment by Dr. Davidson/Dr. Dahl? _____

_____

How did you hear about us?_____

Office Policy:

1. Payment is requested at the time service is rendered.
2. Regardless of insurance coverage, the patient or his/her guardian is responsible for payment in full of all charges for services rendered.

Signature of Patient _____ **Date** _____

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PATIENT MEDICAL HISTORY

Name _____ Date _____

For the following questions, please (X) whichever applies. Your answers are for our records only and will be kept confidential in accordance with applicable laws. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be some additional questions concerning your health. This information is vital in order for us to provide you with appropriate care. This office does not use this information to discriminate.

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your body. Health problems that you have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

	Yes	No	Don't Know
Do your gums bleed when you brush or floss?	☐	☐	☐
Do you grind or clench your teeth?	☐	☐	☐
Are your teeth sensitive to hot or cold liquids/food?	☐	☐	☐
Are your teeth sensitive to sweet or sour liquids/food?	☐	☐	☐
Have you ever had orthodontic (braces) treatment?	☐	☐	☐
Are your teeth sensitive to cold, hot, sweets or pressure?	☐	☐	☐
Do you have ear aches or neck pains?	☐	☐	☐
Have you ever had a major head or neck injury?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐
Do you wear a removable dental appliance(s)?	☐	☐	☐
If yes, please list type(s) and date of placement(s): _____			
_____			
Does dental work make you nervous?	☐	☐	☐
Have you had a serious/difficult problem associated with any previous dental treatment?	☐	☐	☐
If yes, please explain. _____			
Are you currently under a physician's care?	☐	☐	☐
Name of physician/specialist treating you: _____			
For what condition(s)? _____			
Doctor's Phone Number _____			
Doctor's Address _____			
Are you allergic to latex?	☐	☐	☐
Are you allergic to Chlorhexidine Gluconate?	☐	☐	☐

Please list any current medication(s):

_____ for _____
_____ for _____
_____ for _____
_____ for _____
_____ for _____

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PATIENT MEDICAL HISTORY continued

Please circle the appropriate answers below. If you answer yes, please complete the related question.

YES NO Are you allergic to any medication(s)? What? _____
YES NO Do you have high or low blood pressure? HIGH LOW
YES NO Have you ever had pains in the chest/shortness of breath? When? _____
YES NO Have you ever suffered a stroke? When? _____
YES NO Have you ever had hepatitis? When? _____
YES NO Have you ever had a tumor or cancer? What? _____
When? _____
YES NO Do you smoke or use tobacco? How often? _____
YES NO Have you ever been in a serious accident? When? _____
Please explain. _____
YES NO Do you have/have you ever had diabetes? How is it controlled? _____
YES NO Are you taking blood thinners? Which one(s)? _____
YES NO Have you had an artificial joint placed, after which your physician gave you instructions to premedicate before having dental work performed? What is your premedication and dosage? _____

For Women Only:
YES NO Are you pregnant?
YES NO Are you nursing?

Your Height _____ Weight _____ Age _____ Sex _____

Please list any additional special conditions or problems that we should be aware of:

_____
_____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing inaccurate information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____
SIGNATURE OF PATIENT/PARENT/GUARDIAN DATE

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CONSENT TO PERFORM DENTISTRY

1. I hereby authorize and direct the dentist(s) of **Dr. Barret J. Davidson D.D.S.**, and/or dental auxiliaries of his choice, to perform the following dental treatment or oral surgery procedure(s), including the use of any necessary or advisable anesthesia, radiographs (X-rays), or diagnostic aids:
    a. Preventive hygiene treatment (prophylaxis) and the application of topical fluoride
    b. Application of plastic "sealants" to the grooves of the teeth
    c. Treatment of diseased or injured teeth with dental restorations (fillings or crowns)
    d. Replacement of missing teeth with dental prostheses (bridges, partial dentures, full dentures)
    e. Removal (extraction) of one or more teeth
    f. Treatment of diseased or injured oral tissues (hard and/or soft)
    g. Use of sedative drugs to control apprehension and/or disruptive behavior
    h. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities
    i. Use of general anesthesia to accomplish the necessary treatment
2. I understand that there are risks involved in this treatment and hereby acknowledge that these risks will be explained to me, that I will have the opportunity to ask questions regarding the treatment and the risks and that I fully understand the same.
3. I will be advised that the success of the dental treatment to be provided will require that the patient and/or parent(s) of the patient follow post-operative and post-care instructions of the dentist(s). I agree that the success of the treatment requires that all post-operative and post-care instructions be followed and that regular office visits as scheduled by my dentist and his auxiliaries must be maintained.
4. I recognize that during the course of treatment, unforeseen circumstances may necessitate additional or different procedures that are deemed necessary or desirable to oral health and well being, in the professional judgement of this dentist.
5. There are possible risks and complications associated with the administration of local anesthesia, sedation, and drugs. The most common of these are swelling, bleeding, pain, nausea, vomiting, bruising, tingling, and numbness of the lips, gums, face and tongue, allergic reactions, hematoma (swelling or bleeding at or
6. near the injection site), fainting, lip or cheek biting resulting in ulceration and infection of the mucosa. I also understand that there are rare potential risks such as unfavorable reactions to medications in respiratory and cardiovascular collapse (stopping of breathing and heart function) and lack of oxygen to the brain that could result in coma or death. I understand and have been informed of the above risks and complications.
7. I agree tothe use of local anesthesia and the use of nitrous oxide/oxygen analgesia depending on the judgment of the doctor(s). Nitrous oxide/oxygen may occasionally produce nausea and vomiting. I am also aware that the nose piece leaves an indentation or ring around the nose which disappears shortly after the procedure. I understand and have been informed of the above risks and complications.
8. I also authorize the doctor(s) to use my photographs, radiography, router diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.
9. I hereby state that I will have read and understood this consent, and that all questions about the procedures will be answered in a satisfactory manner; and I understand that I have the right to be provided answers to questions which may arise during and after the course of my treatment.
10. *I authorize Texas Sage Dentistry to photograph and/or video my face, jaw, and teeth before, during, and after treatment. I further authorize Texas Sage Dentistry to publish my likeness on their website and social media. I understand that if the photographs and/or videos are published that my name or other identifying information will be kept confidential. I do not expect compensation, financial or otherwise, for the use of these photographs and/or videos.*
    ☑ Yes, I consent.
    ☐ No, I do not consent.
11. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: _____

Name of Parent or Guardian (if applicable): _____

Relationship to Patient: _____

_____

Signature of Patient or Parent/Guardian Date

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Payment Policies

Please sign below to guarantee full payment of your procedure(s).

_____

Name **Signature** **Date**

Payment is **due in full at time of procedure** unless there is a previously agreed upon automatic monthly billing payment in place.

The payment for a denture/crown is due at the final appointment. You may pay half at the first appointment and half at the second.

Payment Options

IF YOU HAVE DENTAL INSURANCE, PLEASE COMPLETE THE FOLLOWING:

Please note, our office is considered "out of network."
Does your insurance pay "out of network?" ☐ YES ☐ NO

Dental Insurance Carrier_____
Group # _____ Patient ID # _____
Name of primary insurance holder/subscriber? _____
Relationship to Subscriber _____
Subscriber Date of Birth _____
Subscriber Address _____
Subscriber SSN or ID# _____
Employed by _____
Occupation _____

_____ Initial here to acknowledge that you guarantee the payment of any balance not covered by insurance.

In an effort to provide access to care, we have a few payment options separate from billing to insurance:

- Cash
- Personal Check
- Credit or Debit Card (MasterCard, Visa, Discover, or American Express)
- In-House Membership Plan
    - Please see our Front Office for more details.