7223 Crosswater Ave
Tyler, Texas 75703

O'NEAL DENTISTRY

Defining the Art of Dentistry

903-561-0533
oneal_dds@yahoo.com

WELCOME.....

Thank you for selecting our dental office. We strive to provide the best possible dental care at affordable prices by practicing preventive dentistry. Every effort will be made to make your visit as pleasant as possible. In order for us to better serve you, please fill out both sides of this form.

PERSONAL INFORMATION: DATE _____

NAME _____ BIRTH DATE _____
LAST FIRST MIDDLE

Married ☐ Divorced ☐ Single ☐ Male ☐ Female ☐ Minor ☐

ADDRESS _____

CITY _____ STATE _____ ZIP _____

HOME PHONE _____ EMPLOYER _____ WORK PHONE _____

CELL PHONE _____ E-MAIL _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

RESPONSIBLE PARTY:

NAME _____ BIRTH DATE _____

RELATIONSHIP TO PATIENT _____ SS# _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMPLOYER _____ WORK # _____

SPOUSE'S NAME _____ BIRTH DATE _____

SPOUSE'S EMPLOYER _____ WORK # _____

DENTAL INSURANCE INFORMATION:

PRIMARY INSURANCE	ADDITIONAL INSURANCE
INSURED'S NAME _____	INSURED'S NAME _____
RELATION TO PATIENT _____	RELATION TO PATIENT _____
INSURER'S BIRTH DATE _____	BIRTH DATE _____
INSURED SS# _____	INSURED SS# _____
EMPLOYER _____	EMPLOYER _____
INSURANCE CO _____	INSURANCE CO _____
GROUP# _____	GROUP# _____
INS PHONE # _____	INS PHONE # _____

(CONTINUE ON BACK)

MEDICAL - DENTAL INFORMATION

REASON FOR VISIT _____

ARE YOU UNDER THE CARE OF A PHYSICIAN? _____ WHAT FOR? _____

PHYSICIAN'S NAME _____ TELEPHONE _____

ARE YOU:

TAKING ANY MEDICATIONS NOW? _____ IF SO WHAT? _____

_____

ALLERGIC TO ANYTHING? _____ IF SO WHAT? _____

USING TOBACCO OF ANY KIND? _____ IF SO WHAT? _____

ARE YOU PREGNANT? _____

DOES THE PATIENT HAVE OR HAD IN THE PAST: (CIRCLE EACH THAT APPLIES)

DIABETES
HEART DISEASE
RHEUMATIC FEVER
CONGENITAL HEART DEFECT / MURMUR
LUNG DISEASE
KIDNEY DISEASE
LIVER DISEASE
HEPATITIS TYPE _____
ABNORMAL BLEEDING
PRIOR RADIATION THERAPY
CANCER

HANDICAP / DISABILITIES
HIGH / LOW BLOOD PRESSURE
JOINT REPLACEMENT
ANEMIA
TUBERCULOSIS
GLAUCOMA
EPILEPSY
TRAUMA TO THE FACE
ASTHMA
HIV / AIDS
OTHER (PLEASE EXPLAIN) _____

_____

In case of emergency contact _____ RELATIONSHIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

_____

For our patients who have dental insurance, we will accept your insurance benefits as part payment for your dental care, however your estimated patient portion will be due at the time of treatment. If for any reason the insurance does not pay what we estimate them to pay, pay what they predetermined, or delays payment more than sixty days, the balance will be due by you to our office. We will work with you to get your deserved benefits but you are responsible for payment of the entire balance to this office. The financial relationship is between you and our office and you and your insurance carrier, not between this office and your insurance company.

I hereby authorize payment of the dental benefits otherwise payable to me directly to Steven M. O'Neal DDS.

Signature (insured person) _____

I have received this practices Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my protected health information, my individual rights and the practice's legal duties with respect to my protected health information.

Signature _____

** Your time is precious, so is ours. An office visit of $69.00 will be charged for appointments cancelled with less than 24 hours notice.