www.ParkCitiesDental.com
J. Eric Hibbs, DDS, FAGD
5600 W. Lovers Lane @ Tollway #216
Dallas, TX 75209-4369 **214.351.2311**

Please fill out this form and click "Submit," or print it, and bring it with you. You may also, e-mail, fax (214-351-2389), or mail form prior to appointment!

Patient Name: _____ **Preferred Name:** _____
Last, First Middle

☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐ **Child** ☐ **Other:** _____

Social Security #: _____ **Driver License #:** _____ **(St):** _____ **Birth Date:** _____

Phone (Hm): _____ **(Wk):** _____ **Ext:** _____ **Cell:** _____

Address: _____
Street Suite/Apt# City State Zip

Employer Name: _____ **Occupation:** _____

Address: _____ **Your E-Mail Address:** _____
Street Suite/Apt# City State Zip

- **How will you secure your account?** ☐ **Credit Card:** _____ **#:** _____ **Expires:** _____
  ☐ **I will pay at time of service during each visit.**
- **Reason for this visit:** _____ **Date of Last Dental Visit:** _____
- **Are you interested in:** ☐ **Fresher Breath** ☐ **Whiter Teeth** ☐ **Changing Appearance of Your Smile**
- **How would you like to set up your initial appointment?** ☐ **Call me** ☐ **I'll call you** ☐ **Send me an e-mail**

Have you ever had or do you now have any of the following? Please check those that apply:

☐ Codeine Allergy ☐ Penicillin Allergy ☐ Sulfa Allergy ☐ AIDS ☐ Allergies: _____ ☐ Anemia
☐ Arthritis ☐ Artificial Joints ☐ Asthma ☐ Blood Disease ☐ Cancer ☐ Diabetes ☐ Dizziness
☐ Epilepsy ☐ Excessive Bleeding ☐ Fainting ☐ Glaucoma ☐ Growths ☐ Hay Fever ☐ Head Injuries
☐ Heart Disease ☐ Heart Murmur ☐ Hepatitis Type: _____ ☐ High Blood Pressure ☐ Jaundice ☐ Kidney Disease ☐ Liver Disease ☐ Mental Disorders ☐ Nervous Disorders ☐ Pacemaker ☐ Pregnancy
☐ Pregnant: Due date: _____ ☐ Radiation Treatment ☐ Respiratory Problems ☐ Rheumatic Fever
☐ Rheumatism ☐ Sinus Problems ☐ Stomach Problems ☐ Stroke ☐ Tuberculosis ☐ Tumors ☐ Ulcers
☐ Venereal Disease ☐ Osteoporosis
☐ **Other, please describe:** _____

- What medications are you taking? _____ Why? _____
- Have you ever had any complications during or following dental treatment? ☐ No ☐ Yes: _____
- Now under the care of a physician? ☐ No ☐ Yes: Name: _____ Ph: _____
- Any health problems that need further clarification? ☐ No ☐ Yes: _____
- Emergency Contact: Name of nearest relative not living with you? _____

Complete address: _____ Ph: _____
Street Suite/Apt# City State Zip

Referral Information

How did you hear about our practice? ☐ Referred by: ☐ Office Sign ☐ Post Card

☐ Dallas Yellow Pages ☐ Park Cities Yellow Pages ☐ Internet Web Site ☐ Other:

Dental Insurance Information

Primary:

Name of Insured: **Is insured a patient?** ☐ **Yes** ☐ **No**

Last, First Middle

Insured's Birth Date: ID #: Group #:

Insured's Address:

Street Suite/Apt# City State Zip

Insured's Employer Name:

Address:

Street Suite/Apt# City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Insurance Plan Name and Address:

Phone #:

Secondary (Additional Insurance):

Name of Insured: Is insured a patient? ☐ Yes ☐ No

Last, First Middle

Insured's Birth Date: ID #: Group #:

Insured's Address:

Street Suite/Apt# City State Zip

Insured's Employer Name:

Address:

Street Suite/Apt# City State Zip

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other:

Insurance Plan Name:

Address: Phone:

Street Suite/Apt# City State Zip

Responsible Party (if other than patient) Information

Name: Relationship to minor patient:

Last, First Middle ☐ Male ☐ Female

Social Security #: Birth Date:

Phone (Hm): (Wk): Ext: Cell:

Address:

Street Suite/Apt# City State Zip

Consent for Services

As a condition of your treatment by this office, the patient is responsible for ensuring payment of the full fee charged for all treatment performed. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed. Patients who require special financial arrangements must notify us in advance.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Estimates of patient co-pay amounts are not a guarantee of the final amount due, which will be determined and billed after all insurance payments have been received.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that dental care fee estimates can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder, as allowed by state law.

I have read the above conditions of treatment and agree to their content. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I hereby authorize any past due amounts to be charged to my securing card account.

To the best of my knowledge, all of the preceding answers and information provided are true and correct.
If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: Relationship to Patient:

Signature of patient, parent or guardian

Additional Comments:

Submit Reset Form