

# THOMAS H. HEFLIN, D. D. S., P. A.

PATIENT INFORMATION & AGREEMENT  
8000 CARMEL NE, ALBUQUERQUE, NM 87122

## PATIENT INFORMATION

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_ Home Phone # \_\_\_\_\_

Cell Phone # \_\_\_\_\_

Business Phone: \_\_\_\_\_ Home Address: \_\_\_\_\_

Email \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Mailing Address (If different from above): \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

The date of patient's last: Cleaning \_\_\_\_\_ Exam \_\_\_\_\_ X-rays \_\_\_\_\_

Who can we thank for referring you? \_\_\_\_\_

Person Responsible for Payment (if not patient): \_\_\_\_\_ Relationship \_\_\_\_\_

Responsible Party Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Responsible Party Social Security #: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Employer Name: \_\_\_\_\_

Dental Insurance? \_\_\_\_\_ yes \_\_\_\_\_ no Insurance Company Name: \_\_\_\_\_

In Case of Emergency Notify: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Patient Primary Physician Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Date of Last Physical: \_\_\_\_\_

## TERMS AND CONDITIONS

Payment is due at time of service. Patient and/or responsible party are ultimately responsible for payment of your account, having insurance is not a guarantee of benefits. Our office will accept assignment of your insurance benefits and file the claims. We will ESTIMATE your co-payment and collect that at the time of treatment. Patient and / or responsible party shall be responsible for costs incurred in enforcing the terms of this agreement including costs of collections and attorney fees. This agreement shall be enforced in accordance with the laws of the State of New Mexico.

Please be aware that there is a fee for no shows/cancellations without a 24 hour notice.

I agree that the information given is correct. I have read and I understand the above statements regarding office policy.

Responsible Party Signature \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH QUESTIONNAIRE

CIRCLE

1. Has there been a change in your general health in the past year? ..... YES NO
2. Have you been a patient in a hospital during the past two years? ..... YES NO  
 If yes, why \_\_\_\_\_
3. Have you been under the care of a physician? ..... YES NO  
 If yes, why \_\_\_\_\_
4. The name of the physician is \_\_\_\_\_
5. Have you taken drugs or medications in the past two years? ..... YES NO
6. If so, what, how much, and how often? \_\_\_\_\_

7. Are you allergic to (i.e., itching, rash, swelling of hands, feet or eyes) or made sick by any drugs or medicine? ..... YES NO  
 Penicillin    Codeine    Aspirin    Novacaine or other local anesthetic
8. Have you ever had any excessive bleeding requiring special treatment? ..... YES NO

9. Circle any of the following which you have or have had:

Heart Failure	Anemia	Artificial Joint	Yellow Jaundice
Heart Disease or Attack	Stroke	X-ray or Cobalt Treatment	Blood Transfusion
Angina Pectoris	Kidney Trouble	Chemotherapy	Drug Addiction
High Blood Pressure	Ulcers	(Cancer, Leukemia)	Hemophilia
Low Blood Pressure	Emphysema	Arthritis	Venereal Disease (Syphilis, Gonorrhea)
Mitral Valve Prolapse	Cough	Rheumatism	Cold Sores
Heart Murmur	Breathing Difficulties	Cortisone Medicine	Genital Herpes
Rheumatic Fever	Tuberculosis (TB)	Glaucoma	Epilepsy or Seizures
Congenital Heart Lesions	Asthma	Pain in Jaw Joints	Fainting or Dizzy Spells
Scarlet Fever	Chronic Bronchitis	Porphyria	Nervousness
Artificial Heart Valve	Hay Fever	AIDS	Psychiatric Treatment
Heart Pacemaker	Sinus Trouble	Hepatitis A (infectious)	Sickle Cell Disease
Heart Surgery	Allergies or Hives	Hepatitis B (serum)	Bruise Easily
	Diabetes	Liver Disease	
	Thyroid Disease		

10. When you walk up stairs or take a walk, do you ever have to stop because of pain in your chest, or shortness of breath, or because you are very tired? ..... YES NO
11. Do your ankles swell during the day? ..... YES NO
12. Do you use more than two pillows to sleep? ..... YES NO
13. Have you lost or gained more than ten pounds in the past year? ..... YES NO
14. Do you ever wake up from sleep short of breath? ..... YES NO
15. Are you on a special diet? ..... YES NO
16. Has your medical doctor ever said you have a cancer or tumor? ..... YES NO
17. Have you ever had surgery or x-ray treatment for a tumor? ..... YES NO
18. Do you have any disease, condition, or problem not listed? ..... YES NO

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

19. WOMEN: Are you pregnant now? ..... YES NO  
 Do you anticipate becoming pregnant? ..... YES NO

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform you at the next appointment.

Date \_\_\_\_\_ Signature \_\_\_\_\_

THOMAS H. HEFLIN, D.D.S., P.A.

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ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES

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\*You May Refuse to Sign This Acknowledgement\*

I, \_\_\_\_\_, have received a copy of this office's Notice of  
Privacy Practices.

\_\_\_\_\_  
Please Print Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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For Office Use Only

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We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but  
acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us to obtain acknowledgement
- Other (Please Specify)

\_\_\_\_\_  
\_\_\_\_\_

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## FINANCIAL POLICY

We are committed to providing you with the best possible care. If you have dental insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and understanding of our payment policy.

Your applicable payment or co-payment for services is due at the time services are rendered. We accept, cash, check, MasterCard, Visa, Discover Card or American Express. Payment programs are also available; please speak with the front office for more details. We will be happy to process your insurance claim form provided we have all the required information to do so. Secondary insurance billing is patient responsibility.

We will gladly discuss your proposed treatment and answer any questions relating to your insurance to the extent we are able. **You must realize, however, that your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract.**

We must **emphasize**, that as health care providers, our relationship is with you, not your insurance company. Assisting in the filing of insurance claims is a courtesy we extend to our patients. All charges are your responsibility from the date the services are rendered.

If you have any questions about the above information, or any uncertainty regarding payment, PLEASE do not hesitate to ask us. We are here to help you.

I understand, and agree to follow all the above information.

Signed \_\_\_\_\_ Date \_\_\_\_\_