Appointment Process

We love to make you smile!

We are always welcoming new patients to our office in the heart of Las Colinas. Whether you're looking for cosmetic dentist to help improve your smile, or if you are new to the area and are looking for a family dentist, we would love to see you.

We see all ages, as young as six months to infinity in our soothing and relaxing atmosphere. Our office is opened Monday through Thursday 9am-Spm and Friday 9am-1pm. Our lunch time is lpm to care for the patients who prefer to come in on their lunch hour. We know that your time is important, and we work to ensure that your visit happens as professionally and quickly as possible. We value your time and loyalty. As a result we set aside time just for you. If you need to cancel or change your dental ap-pointment we request that you give us 48 hours' notice.

There are several options available for your visit:

Cosmetic Dental Consultation:

At any time you can schedule a free thirty minute consultation with Dr. Rabile to discuss your smile.

She will personally meet with you to discuss how your smile can be improved or changed to help you achieve the perfect smile.

New Patient exam and cleaning:

If you decide that you would like to become a new patient, we would be happy to schedule you a new patient exam and cleaning. You will come into the office for a fifty minute exam and consultation with Dr. Rabile. She will meet with you and perform a comprehensive examination of your mouth including teeth, gums, take any necessary X-rays and discuss any concerns you may have with your smile. You will then receive the complete dental cleaning that best meets your needs and an oral cancer check.

The cleaning can be done the same day as your first visit if the time allows.

Emergency exam and palliative treatment:

According to a study by the surgeon general of the United States, every year 168 million work hours are lost in the U.S. due to dental conditions. Our goal is to limit this time through regular maintenance.

However, emergencies do happen. We understand this and do everything in our power to take care of them quickly and conveniently. At your emergency appointment we will diagnose the problem and if you desire and time allows to treat it at that time.

Routine and Maintenance appointment with cleanings:

Once your treatment is completed, you will need to keep your routine checkups as your teeth and gums according to the recommended intervals. This step is critical for your mouth to remain in the desired healthy state.

Health History & Registration

PATIENT INFORMATION

PATIENT'S NAME Last_____ First _____ MI___ Sex: M F Birthdate_____ Age_____
Soc. Sec.# _____If Patient is a minor, give Parent or Guardian's name_____ Today's Date_____
Who may we thank for referring you to our office? _____ Reason for visit_____

RESPONSIBLE PARTY INFORMATION

NAME Last _____ First_____ MI ____Marital status_____
RESIDENCE Street _____ Apt#_____ City_____ State_____ Zip_____
MAILING ADDRESS Street_____ Apt#_____ City_____ State_____ Zip_____
HOW LONG AT THISS ADDRESS_____ Home Phone #_____ Cell Phone #_____
Work Phone#_____ E-Mail _____
Soc. Sec. # _____ Birthdate_____ Drivers License #_____ Relation to patient_____
Employer_____ Occupation_____ No. yrs employed _____

RESPONSIBLE PARTY SPOUSE

NAME Last_____ First _____MI____ Birthdate_____ Soc. Sec. # _____
Employer_____ Occupation _____No. yrs employed_____
Home Phone#_____ Cell Phone#_____ Work Phone#_____ E-Mail_____

EMERGENCY INFORMATION

Name_____ Relationship_____ Home Phone#_____
Address_____ City, State, Zip _____ Cell Phone #_____

DENTAL INSURANCE INFORMATION (Primary)

Insured's Name_____ Insurance Co. _____Soc Sec. #_____
Insurance Co. Address _____ City, State, Zip _____Group #_____

If you have double dental insurance coverage, complete this for the second coverage

Insured's Name_____ Insurance Co._____ Soc. Sec. #_____
Address_____ City, State, Zip _____ Group #_____

DENTAL HISTORY		
Date of last full mouth X-Ray		
Are you having problems now?	**Y**	**N**
What?		
Is your dental health poor?	**Y**	**N**
Do you have headaches, earaches or neck pains?	**Y**	**N**
Do you wear dentures?	**Y**	**N**
Are you unhappy with your dentures?	**Y**	**N**
Would you like to know about permanent replacements?	**Y**	**N**
Are you apprehensive about dental treatment?	**Y**	**N**
Have you had any periodontal (gum) treatments?	**Y**	**N**
Have you worn braces before?	**Y**	**N**
Do you regularly use floss?	**Y**	**N**

MEDICAL HISTORY		
Do you have any current health problems?	**Y**	N
Are you under the care of a physician?	Y	N
For what?		
What medications are you taking?		
Are you pregnant?	Y	N
Do you use cigarettes or chewing tobacco	**Y**	**N**
Name of previous dentist:		
City:		
State:		
Family physician:		
Phone:		
E-Mail:		

Please circle if you have or have had the following:

AIDS	Circulatory Problems	Stroke
Anaphylaxis	Heart issues	Tonsillitis
Anemia	Hemophilia	Ulcer
Arthritis	Kidney disease	Tuberculosis
Artificial joints	Liver disease	Swelling
Asthma	Nervous problems	Diabetes
Atopic	Psychiatric care	Epilepsy
Back problems	Weight gain	Fainting
Blood disease	Weight loss	Herpes
Chemotherapy	Radiation Tx	Hepatitis
Headaches	Respiratory disease	Jaw pain
Cortisone Tx	Scarlet fever	Glaucoma
Cough	Shingles	Allergies
Cough blood	Short of breath	Rash
Food allergies	Thyroid disease	Cancer

ARE YOU ALLERGIC OR HAVE YOU ACTED ADVERSELY TO ANY MEDICATIONS? ANY OTHER ALLERGIES?

Signature of patient_____
Date_____

Smile Analysis

Today's Date_____ Patient Number _____

1. **Do you love the way your smile looks?** ☐ Yes ☐ No

2. **Do you feel comfortable showing your teeth when you laugh or smile?** ☐ Yes ☐ No

3. **If you could change anything about your smile, it would be (check all that apply) :**

   ☐ Color of your teeth ☐ Too much or too little of teeth show when you smile
   ☐ Gaps between your teeth ☐ Size/Shape of your teeth ☐ Alignment of your teeth
   ☐ Too much or too little gum shows when you smile ☐ Other_____

4. **Do you have (check all that apply) :**
   ☐ Sensitive or receding gums ☐ Worn/Broken/Chipped teeth ☐ Old or discolored fillings
   ☐ Missing teeth ☐ Old crowns that have dark edges at the top ☐ Other _____

5. **In your line of work or lifestyle, do you (check all that apply):**
   ☐ Visit businesses or clients ☐ Travel ☐ Speak publically ☐ Other _____

6. **If you had a smile makeover do you think you'd feel (check all that apply) :**
   ☐ More confident ☐ More optimistic ☐ Healthier ☐ Just OK
   ☐ No different ☐ Other _____

7. **Do you or someone in your family have issues with any of the following (check all that apply) :**
   ☐ Chronic bad breathe ☐ Grinding teeth ☐ Snoring ☐ Other _____

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the section at the bottom of form

Patient Name_____

☐ **1. WORK TO BE DONE**

I understand that I am having the following work done: Fillings_____ bridges _____ Crowns_____ Extractions _____ Impacted teeth removed _____General Anesthesia_____ Root Canals_____ Other_____

(Initials _____)

☐ **2. DRUG AND MEDICATIONS**

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, Pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Chemical burns to face can cause scarring.

☐ ***(Initials _____)***

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on that teeth that we are not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

☐ ***(Initials _____)***

4. *REMOVAL OF TEETH*

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc) and I authorize the dentist to remove the following teeth _____ and any others necessary for reason in paragraph #3. I understand removing teeth does not always remove all the infection, and if present, and it may be necessary to have further treatment. I understand the risk involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need farther treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

☐ ***(Initials _____)***

5. CROWN, BRIDGES AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may came off easily and that I must careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit size, and color) will be before cementation.

☐ ***(Initials _____)***

6. DENTURES, COMPLETE OR PARTIAL

I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

(Initials _____)

☐ **7. ENDODONTIC TREATMENT (ROOT CANAL)**

I realize there is no guarantee that root canal treatment will save my tooth, and the complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend the root, which does not

necessarily affect the success of the treatment, I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

☐ ***(Initials _____)***

8. <u>PERIODONTAL LOSS (TISSUE & BONE)</u>

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacement and /or extractions. I understand that undertaking any dental procedures may have a future adverse effect on my periodontal condition.

(Initials _____)

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee result. I acknowledge that no guarantee or assurance has been mad by anyone regarding the dental treatment which I have requested and consent to the proposed treatment.

Signature of patient_____
Date_____

Signature of parent/Guardian if Patient is a minor_____
Date_____

Dear Valued Patient,

We at Rabile Family Dentistry take pride in our warm, caring atmosphere. One aspect we really enjoy about our practice is the opportunity to offer quality care and individual attention to each and every patient. We like having that personal time with you. When that time is lost due to an appointment cancellation, other patients in need of treatment cannot be seen and your treatment is delayed. For these reasons, we have the following office policy:

Appointment Cancellation Policy

We will make every effort to remind patients by telephone and Email prior to the appointment but please do not depend on this courtesy. We have found that with the recent popular use of answering machines, pagers, and voice mail, and Emails some of our patients are not receiving our reminder calls and messages due to the occasional malfunction of these devices. If you use such devices, we kindly ask that you return our call or Email to confirm that you received our message. If we are unable to contact you directly, your appointment card (which will be mailed out 2 weeks prior to your appointment) or appointment phone call will serve as confirmation of your appointment and it implies your obligation to be present. Your appointment time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $30 cancellation fee. If commitments for appointments are frequently broken, we will not be able to pre-schedule your appointment. You will then have to call on the day you can make it in, to see if we can fit you in for that day.

Our ultimate goal is to help you achieve optimum dental health. Broken appointments only serve to delay your dental care and the opportunity to achieve that goal. Thank you for your cooperation. We look forward to seeing you on your next appointment.

Sincerely,
Dr. Hodan Rabile & Staff

X_____ Date_____
signature

Financial Policy

We at Rabile Family Dentistry are dedicated to serving you in caring for your oral health. We take great pride and care in providing the best in dental care to you and your family. Therefore, we will be more than happy to assist you with any financial matter related to your dental needs.

We ask for payment in full at each dental visit. To accommodate you with this we accept the following methods of payment:

1. Cash
2. Check
3. Credit card

For our patients with dental insurance, we will be happy to file your primary insurance claims for you at no charge. We will file a predetermination (per request) for any dental treatment that we deem necessary. The predetermination that we receive back from your insurance company is not a guarantee of payment. Your estimate portion is due in full at the time that services are rendered.

Your insurance plan is an agreement between you and your insurance company. If your insurance company fails to make payment on your claim then the balance will become yours after sixty days. All accounts that go beyond sixty days past due will be transferred to our legal department. If payment is made on your claim and it is less than we originally estimated then the remaining balance, in full, will become your responsibility.

We firmly believe that the insurance company does not have the right to decide what course of treatment is best for you. Their decisions about your care are not always up to our standard of care and we refuse to neglect you, our patient, because of this.

By signing this form I authorize payment directly to Dr. Hodan Rabile (Rabile Family Dentistry) and I agree to abide by the following guidelines:

- A charge of $30 will apply to my account if my check is returned for insufficient funds.
- I agree to keep all appointments as scheduled or I will be charged a $30.00 cancellation fee for any missed or broken appointment.

Print name Patient/Guardian Signature Date

_____ _____ _____