

Patient Information

Patient Name: _____ Date: **01/21/2026**
FIRST NAME M.I. LAST NAME
 Address: _____ City: _____
 State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____
 Employer: _____ Work Phone: _____
 Date of Birth: _____ Age: _____ Social Security Number: _____
 Patient Referred By: _____ General Dentist: _____
 Family Physician: _____ Marital Status: Single Married
 Spouse's Name: _____
FIRST NAME LAST NAME
 Email: _____ Emergency Contact: _____
 Emergency Contact Phone: _____

RESPONSIBLE PARTY INFORMATION

Person Responsible for Account: _____ Relation to Patient: _____
FIRST NAME LAST NAME
 Address of Responsible Party: _____ City: _____
 State: _____ Zip: _____ Employer: _____
 Address: _____ Phone: _____

MEDICARE PATIENTS: DR. IERO IS NOT A MEDICARE PROVIDER. YOUR SERVICES RENDERED IN OUR OFFICE ARE NOT BILLABLE TO MEDICARE.

PRIMARY DENTAL INSURANCE

Insurance Co.: _____
 ID #: _____
 Policyholder: _____
FIRST NAME LAST NAME
 Relationship to Patient: _____
 Policyholder S.S. #: _____
 Date of Birth: _____
 Employer/Group #: _____
EMPLOYER GROUP #
 Insurance Address: _____
STREET
CITY STATE ZIP
 Insurance Phone #: _____

PRIMARY MEDICAL INSURANCE

Insurance Co.: _____
 ID #: _____
 Policyholder: _____
FIRST NAME LAST NAME
 Relationship to Patient: _____
 Policyholder S.S. #: _____
 Date of Birth: _____
 Employer/Group #: _____
EMPLOYER GROUP #
 Insurance Address: _____
STREET
CITY STATE ZIP
 Insurance Phone #: _____

I (We), the undersigned, hereby agree to pay all amounts and charges incurred by myself and members of my family for services rendered by Dr. Phillip T. Iero according to the financial policies established.

In the event that Dr. Phillip T. Iero agrees to file insurance claims for myself or my family, I authorize the release of any medical information necessary to process that claim and request that payment of benefits be made to Dr. Phillip T. Iero. I further agree to pay any amount not covered by my insurance company.

PATIENT/RESPONSIBLE PARTY SIGNATURE: _____

PLEASE COMPLETE MEDICAL INFORMATION ON THE NEXT PAGE

Medical History

Patient Name: _____

Age: _____ **Weight:** _____ **Height:** _____

Please answer the following questions regarding your medical history. All answers are kept confidential.

- Are you currently under the care of a physician? Yes No
- Have you had an adverse effect from dental treatment? Yes No
- Have you had or do you currently have cancer? Yes No
 If so, please specify: _____
- Have you had complications from anesthesia? Yes No
- Do you wear contacts? Yes No
- Do you smoke? Yes No
 If so, how often? _____
- Do you consume alcohol? Yes No
 If so, how often? _____
- Have you ever sought professional treatment for drug abuse, alcoholism, or emotional disorders? Yes No
- Do you have or have you ever had any of the following?

<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Asthma	<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Frequent Mouth Sores
<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Implants Placed (knee, hip, heart valve, dental)?
<input type="checkbox"/> Heart Problems	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Grinding of Teeth
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Stroke	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> Immune Suppressing Disease (HIV/AIDS)
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Seizures	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Recurring Infections
<input type="checkbox"/> Heart Surgery	<input type="checkbox"/> Anemia	<input type="checkbox"/> Stomach Ulcers or Colitis	
<input type="checkbox"/> Pacemaker Installed	<input type="checkbox"/> Bleeding Tendency	<input type="checkbox"/> Glaucoma	

WOMEN ONLY: Are you pregnant? Yes No

- Do you have any other disease or condition that was not listed? Yes No

If so, please explain: _____

- Have you ever had surgery? Yes No

If so, list the type of surgery and the year: _____

Financial & Scheduling Policies

We are committed to providing the finest, most comprehensive care available today. In order for us to achieve this goal, it is important that you understand our financial and scheduling policies.

1. Payment for all services is due at the time services are rendered.

There is a fee for today's consultation and examination. If you have insurance, we will be happy to file for you, but know that the portion not covered is your responsibility. Your surgery treatment plan and cost will be presented to you immediately following your consultation with Dr. Iero.

2. We accept the following forms of payment:

- Cash
- All major credit cards
- Cashier's checks
- CareCredit

3. We will accept benefits from your insurance carrier and file your claims as a courtesy to you. Please note that if our office is not contracted with your insurance carrier, we will only accept out-of-network assignments. It is important to remember that the information we receive from your insurance carrier is only an estimate of benefits, and we cannot be responsible for any discrepancies in benefits reported. Any unpaid balances from insurance after 60 days will become the patient's responsibility.

4. A 10% nonrefundable down payment is due to schedule surgery.

5. Surgery cancellations and reschedules must be made at least five business days prior to the original surgery date. Failing to do so could result in a charge equal to 10% of total surgical fees in addition to the nonrefundable deposit.

6. Your surgery will be scheduled to allow proper time for the procedure and recovery. If you decide to alter the originally agreed-upon treatment plan, you must notify our office 72 hours prior to surgery to allow us to make rearrangements in our schedule. Failing to do so will result in a 10% fee of the original treatment plan in addition to the nonrefundable deposit.

7. Please arrive no later than the confirmed appointment time. If you see that you will be late, it is your responsibility to contact our office immediately to avoid cancellation or delay of your surgery.

Signature (Patient/Responsible Party)

Date:

Release of Information

I hereby authorize Bellaire Facial, Oral & Dental Implant Surgery to furnish information concerning any treatment rendered to me to my insurance carrier, to any physician who referred me to Bellaire Facial, Oral & Dental Implant Surgery, and to any medical practitioner or dentist that the Bellaire Facial, Oral & Dental Implant Surgery physician may refer me to for further medical or therapy treatment. This authorization remains in effect unless revoked by me in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

Bellaire Facial, Oral & Dental Implant Surgery reserves the right to modify the privacy practices outlined in the notice. I have received a copy of the Notice of Privacy Practices for Bellaire Facial, Oral & Dental Implant Surgery.

Name of Patient: _____

Signature of Patient: _____

Date: _____

Signature of Patient Representative: _____

(Required if patient is a minor or adult that is unable to sign this form)

Relationship of Patient Representative to Patient: _____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

USES AND DISCLOSURES

Treatment: Your health information may be used by staff members or disclosed to other healthcare professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Healthcare Options: Your health information may be used as necessary to support the day-to-day activities and management of Bellaire Facial, Oral & Dental Implant Surgery. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Other Uses and Disclosures Requiring Your Authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

ADDITIONAL USES OF INFORMATION

Appointment Reminders: Your healthcare information will be used by our staff to send you appointment reminders.

Information About Treatments: Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

Individual Rights:

You have certain rights under the federal privacy standards. These include

- The right to request on the use and disclosure of your protected health information
- The right to receive confidential communications concerning your medical condition and treatment
- The right to inspect and copy your protected health information
- The right to amend or submit corrections to your protected health information
- The right to receive an accounting of how and to whom your protected health information has been disclosed
- The right to receive a printed copy of this notice

Bellaire Facial, Oral & Dental Implant Surgery Duties: We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We also are required to abide by the privacy policies and practices that are outlined in this notice.

Notice of Privacy Practices

Right to Revise Policy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Request to Inspect Protected Health Information: You have the right to inspect or copy the protected health information that we maintain, permitted by federal regulation. We require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Practice Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Front Desk
Bellaire Facial, Oral & Dental Implant Surgery
6800 West Loop South, Suite 350
Bellaire, TX 77401

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address.

You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person

The name and address of the person you can contact for further information concerning our privacy practices is:

Front Desk
Bellaire Facial, Oral & Dental Implant Surgery
6800 West Loop South, Suite 350
Bellaire, TX 77401
(713) 665-9200