Michael D. Masera
D.D.S., Inc.

9660 Hillcroft Street, Suite 110, Houston, TX 77096 | 713-723-5615

Patient Information:

Patient Name: _____ Preferred Name: _____

Birth Date: _____ Male: ☐ Female: ☐ Married: ☐ Single: ☐ Minor: Y N

SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

E-mail address: _____ Best way to reach you: _____

Employer: _____

Emergency Contact: _____ Phone #: _____

Other family members seen by us: _____

How did you hear of us? _____

If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient: _____

Birth Date: _____ SS#: _____ Driver's License #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Work #: _____ Cell #: _____

Dental Insurance Information (Primary):

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self ☐ Spouse ☐ Child ☐ Other ☐

Dental Insurance Information (Secondary):

Policyholder's Name: _____ Birth Date: _____ SS#: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID#: _____

Patient Relationship to Policyholder: Self ☐ Spouse ☐ Child ☐ Other ☐

Do you like your smile? Yes No

What, if anything, would you change about your smile? _____

Why have you come to the dentist today? _____

Are you currently in pain? Yes No Do your gums bleed? Yes No How many times a day do you brush? _____

Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Yes No

Have you ever had problems with previous dental treatment? Yes No

If yes, please explain: _____

Previous Dentist or Dental Office: _____ When was last dental visit? _____

Do you smoke or use chewing tobacco? Yes No If yes, how long? _____ How often? _____

Physician's Name: _____ Phone #: _____

Have you ever had a serious head, neck, or back injury? _____

WOMEN: Are you or could you be pregnant? Y N Are you nursing? Y N Taking Oral Contraceptives? Y N

Are you currently being treated for or have you ever been treated for any of the following? Please circle all that apply:

☐ Rheumatic Fever	☐ Epilepsy/Seizures	☐ Tuberculosis	☐ Hepatitis	☐ Low Blood Pressure
☐ Heart Murmur	☐ Diabetes	☐ Asthma	☐ HIV/AIDS	☐ High Blood Pressure
☐ Mitral Valve Prolapse	☐ Glaucoma	☐ Sinus Problems	☐ Blood Transfusion	☐ Heart Attack/Stroke
☐ Artificial Valve/Joint	☐ Arthritis	☐ Cancer/Chemo	☐ Drug/Alcohol Abuse	☐ Pacemaker
☐ Any implant/transplant	☐ Kidney Problems	☐ Severe Headaches	☐ Psychiatric Care	☐ Excessive bleeding/Bruise easily
☐ Thyroid problems	☐ Heart surgery	☐ Autism		

Please list any medical condition not listed above: _____

Are you allergic to any of the following? PLEASE CIRCLE YES or NO FOR EACH ONE.

Latex Y N Penicillin Y N Aspirin Y N Erythromycin Y N Codeine Y N Tetracycline Y N

Ibuprofen Y N Tylenol Y N Sulfa Y N Dental Anesthetics Y N

Other _____

Please list all medications you are currently taking: _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my medical status.

Patient Signature: _____ Date: _____

Parent/Guardian Signature **if patient is a minor**: _____ Date: _____

2026

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Insurance Information, Assignment and Release

As many of you know throughout the years insurance benefits have changed. The New Year started and there will probably be more changes this year. We do not always know what these changes will be until the insurance companies start processing the claims. We will do our best to help you understand your benefits, but we ask our patients to please read their insurance benefit booklet, so you can stay on top of any existing and new information.

There are hundreds of PPO insurance companies, and it is impossible to belong to all of them. We do, however, feel we are very competitive (fair) with our office fee schedule. We try to remain in the average range for our area, when it comes to fees.

There are certain guidelines that should be outlines in your benefits booklet, such as, how many cleanings and exams you may have in one year, what your deductible and maximum is and basic inclusions and exclusions. If you have been to another office and have used part of your dental maximum, this will affect the amount of benefit you have remaining to use in our office. If you have college age children, you may need to send proof of student status to your insurance company to have your child be eligible for benefits. We do our best to be as accurate as we can, but the ultimate responsibility is with the Subscriber (patient/parent) to pay whatever your insurance company does not pay in our office. If the insurance company does not pay the estimated amount to our office you will be responsible to pay the balance of your account within 30 days.

I certify that I and my dependent have insurance coverage with _____ and I am assigning the benefits directly to Dr.Masera I know I am financially responsible for any balance not paid by my insurance company for me or my dependent(s). I understand that Dr. Masera's office is giving me an estimation of the amount my insurance company will assist me (my family) with for necessary services, but I do not hold them responsible in the event that my insurance company does not reimburse the benefit as expected.

This consent is valid for one year or until December 31, 2025, for me and any dependent(s).

Signature of Patient, Guardian or Personal Representative _____

Print Name of Patient, Guardian or Personal Representative _____

Relationship to patient _____

Date _____

OralID™
The 2 minute exam that can SAVE your life.

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID™ screening device into our office. The OralID™ examination will allow us to visualize any oral mucosal abnormalities including cancer and dysplasia (pre-cancer) before they can be detected with the naked eye. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of Oral Cancer is critical. Studies have shown that early detection of oral cancer with technologies like the OralID™ dramatically improves the survivability of the disease. If oral cancer is detected in its later stages, which typically occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID™ to reduce the mortality of late stage detection.

Our office fee for this procedure is $25.00 for the year.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

_____

Signature Name Date

☐ No, I prefer to not have this examination at this visit.

_____

Signature Name Date

HIPAA COMPLIANCE

In compliance with the Federal HIPAA policy, we are requesting your permission to send out appointment reminders via postcards to the address on file. These postcards will have your name, address, time, and date of the appointment viewable by the post office.

I give Michael D. Masera, D.D.S. dental office permission to send appointment reminders via postcards.

Patient/Guardian Signature _____Date _____