

Welcome to Herring Family Dental

Thank you for Choosing our Dental Team

Patient Information

Child's Name _____ Nickname _____
Last First Middle Initial
Home Address _____ City _____ State ____ Zip _____
Home Phone Number_(____) _____ Birthday _____ Age _____
School _____ Grade _____

Mother

Mother Stepmother Guardian

Name _____
Home Phone_(____) _____
Work Phone_(____) _____
Cell Phone_(____) _____
Social Security # _____
Employer _____
Driver's License # _____
Email _____

Father

Father Stepfather Guardian

Name _____
Home Phone_(____) _____
Work Phone_(____) _____
Cell Phone_(____) _____
Social Security # _____
Employer _____
Driver's License # _____
Email _____

Parent's Marital Status Married Separated Divorced

Responsible Party

Name _____ Relationship to Patient _____
Home Address _____ City _____ State ____ Zip _____
Home Phone_(____) _____ Work Phone_(____) _____ Cell Phone_(____) _____
Social Security # _____ Driver's License # _____ Email _____

Insurance Information

Does Your Child Have Dental Insurance? Yes No

Dental Insurance Information

Name of Insured _____ Birthday _____

SS# _____ Driver's License# _____ Email _____

Employer _____ Relationship to Patient _____

Is this person currently a patient in our office? Yes No

Insurance Company _____ Telephone # of Insurance Co. _(____) _____

Address to Mail Claims _____ City _____ State _____ Zip _____

Group # _____ Subscriber ID # _____

Does Your Child Have Additional Insurance? If Yes, Please Complete the Following

Secondary Dental Insurance Information

Name of Insured _____ Birthday _____

SS# _____ Driver's License# _____ Email _____

Employer _____ Relationship to Patient _____

Is this person currently a patient in our office? Yes No

Insurance Company _____ Telephone # of Insurance Co. _(____) _____

Address to Mail Claims _____ City _____ State _____ Zip _____

Group # _____ Subscriber ID # _____

Health History

1. Has your child had difficulty with previous dental visits? _____
2. Does your child have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)? _____

3. Has your child ever had any of the following?

Asthma	Y	N	Cancer	Y	N	Rheumatic Fever	Y	N
HIV/AIDS	Y	N	Hemophilia	Y	N	Congenital Heart Defect	Y	N
Diabetes	Y	N	Heart Murmur	Y	N	Handicaps/Disabilities	Y	N
Hepatitis	Y	N	Tuberculosis	Y	N	Convulsions/Epilepsy	Y	N

4. Does your child have any allergies to the following?

Local Anesthetics (e.g. Novocain)	Yes	No
Penicillin	Yes	No
Sulfa Drugs	Yes	No
Barbiturates	Yes	No
Sedatives	Yes	No
Iodine	Yes	No
Aspirin	Yes	No
Metals	Yes	No
Latex Rubber	Yes	No
Other (please list below)	Yes	No

How often does your child brush? _____ Floss? _____

Date of last dental visit _____ Previous Dentist Name _____

Child's Physician _____ Phone #_(____)_____

Is your water fluoridated? Yes No Unsure

Does your child:	Take fluoride supplements?	Yes	No
	Suck thumb/finger?	Yes	No
	Bite/Chew nails?	Yes	No
	Chew hard objects (pencils, etc)?	Yes	No
	Grind Teeth?	Yes	No
	Clench Jaws	Yes	No

Has your child ever had orthodontics (braces)? Yes No

Are you interested in orthodontics for your child? Yes No

Insurance Policy

Herring Family Dental will be happy to file any PPO Dental Insurance on your behalf. However, it is your responsibility to know your benefits. In many cases, insurance companies will not pay the total amount charged. Any amount left over that your insurance company did not pay will be your responsibility. Herring Family Dental is not in-network with any insurance companies; therefore please understand that any remaining amount not paid by your insurance company will be an out-of-pocket expense to you.

Signature

Date

Payment Policy

Payment for all services is expected when services are rendered. Herring Family Dental will be happy to work out a payment arrangement if needed. There is no interest for our payment arrangements; however we do require a debit or credit card number. For more information on payment arrangements please ask the Herring Family Dental Staff.

Signature

Date

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to the third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature

Date

Staff Initials _____ Date _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Summary:

By law, we are required to provide you with our Notice of Privacy Practices (NPP). This Notice describes how your medical information may be used and disclosed by us. It also tells you how you can obtain access to this information. As a patient, you have the following rights:

1. The right to inspect and copy your information;
2. The right to request corrections to your information;
3. The right to request that your information be restricted;
4. The right to request confidential communications;
5. The right to a report of disclosures of your information; and
6. The right to a paper copy of this Notice

We want to assure you that your medical/protected health information is secure with us. This Notice contains information about how we will insure that your information remains private.

If you have any questions about this Notice, please contact:

Dr. Patricia Herring, D.D.S.
Dr.Tami Herring-Sahni, D.D.S
Herring Family Dental
164 S. Union
New Braunfels, TX 78130
(830) 620-0000

Signature of Patient or Legal Representative

Date

Printed Name of Patient or Legal Representative

IF HERRING FAMILY DENTAL WILL BE FILING INSURANCE ON YOUR BEHALF, PLEASE SIGN THE FOLLOWING

Authorization To Release Personal Information

I, _____ authorize my insurance company to release benefit and or claim information to Herring Family Dental and or e-claims (insurance processors). I also authorize the office of Herring Family Dental to release necessary information to my insurance company and or e-claims to file my claim. This information will only be used to file insurance claims. I understand this consent is effective until I revoke it in writing, and that insurance claims filed will still be processed should I revoke consent.

Signature of Patient or Legal Representative

Date