

*Herring Family Dental*

164 S. Union Ave.

New Braunfels, TX 78130

(830) 620-0000

*Thank You for Selecting Our Dental Team*

*Patient Information*

Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Last

First

Middle Initial

SS# \_\_\_\_\_ Driver's License# \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone\_(\_\_\_\_)\_\_\_\_\_ Work Phone\_(\_\_\_\_)\_\_\_\_\_ Cell Phone\_(\_\_\_\_)\_\_\_\_\_

Check Appropriate Box    Single    Married    Separated    Divorced    Widowed

Employer \_\_\_\_\_ Full Time    Part Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse Name \_\_\_\_\_ Phone #\_(\_\_\_\_)\_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone #\_(\_\_\_\_)\_\_\_\_\_

Whom May We Thank For Referring You? \_\_\_\_\_

*Responsible Party* if different from above

Name of Person Responsible for this Account \_\_\_\_\_ Birthday \_\_\_\_\_

SS# \_\_\_\_\_ Driver's License# \_\_\_\_\_ Email \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone\_(\_\_\_\_)\_\_\_\_\_ Work Phone\_(\_\_\_\_)\_\_\_\_\_ Cell Phone\_(\_\_\_\_)\_\_\_\_\_

Employer \_\_\_\_\_ Full Time    Part Time

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Is this person currently a patient in our office?    Yes    No    Relationship to Patient \_\_\_\_\_

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Do You 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 # \_\_\_\_\_

**Do you 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 # \_\_\_\_\_

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*Patient Medical History*

Physician \_\_\_\_\_ Phone # (\_\_\_\_\_) \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

- 1. Are You Under Medical Treatment Now? Yes    No
- 2. Have you been hospitalized within the last 5 years? Yes    No

If yes, please explain: \_\_\_\_\_  
\_\_\_\_\_

- 3. Are you taking any medications? (prescription and over-the-counter) \_\_\_\_\_

- 4. Have you ever taken Fen-Phen/Redux? Yes    No
- 5. Do you use tobacco? Yes    No
- 6. Do you use controlled substances? Yes    No
- 7. Do you drink alcohol? Yes    No
- 8. Are you wearing contact lenses? Yes    No
- 9. Are you allergic to or have you had any reactions 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

- 10. Do you have a persistent cough or throat clearing no associated with a know illness lasting more than three weeks? Yes    No

*For Women Only*

- Are you pregnant or think you may be pregnant? Yes    No
- Are you nursing? Yes    No
- Are you taking oral contraceptives? Yes    No



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*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

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**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

