

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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Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia/ Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Angina	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement/Implant	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>						
Other -	_____							

Patient Dental History

Name of Previous Dentist _____ City _____ Date of Last Visit _____

- Do your gums bleed while brushing or flossing? Yes No
- Are your teeth sensitive to hot or cold liquids or foods? Yes No
- Are your teeth sensitive to sweet liquids or foods? Yes No
- Do you feel pain to any of your teeth? Yes No
- Do you have any sores or lumps in or near your mouth? Yes No
- Have you had any head, neck or jaw injuries? Yes No
- Have you ever experienced any of the following problems in your jaw?
 - Clicking Yes No
 - Pain (joint, ear, side of face) Yes No
 - Difficulty in opening or closing Yes No
 - Difficulty in chewing Yes No
- Do you have frequent headaches? Yes No
- Do you clench or grind your teeth? Yes No
- Do you bite your lips or cheeks frequently? Yes No
- Have you had any difficult extractions in the past? Yes No
- Have you had prolonged bleeding following extractions? Yes No
- Have you had orthodontic treatment? Yes No
- Do you wear dentures or partials? Yes No
- Do you like your smile? 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

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