PATIENT'S NAME: _____ **DOB:** _____
(Last) (First) (MI)

PATIENT'S PREFERRED NAME: _____ **SS #:** _____ MALE FEMALE

RESPONSIBLE PARTY: _____ **DOB:** _____
(Last) (First) (MI)

RELATIONSHIP TO RESPONSIBLE PARTY: _____

RESP. PARTY PREFERRED NAME: _____ **SS #:** _____ MALE FEMALE

RESP. PARTY MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED OTHER

HOME ADDRESS: _____ **MAILING ADDRESS:** _____

(No P.O. Boxes) _____ _____

_____ _____

PHONE NUMBERS: **EMERGENCY CONTACT:**

HOME: _____ NAME: _____

WORK: _____ RELATIONSHIP: _____

CELL: _____ PHONE: _____

EMPLOYER: _____ POSITION: _____ HOW LONG? _____

DRIVERS LICENSE #: _____ **STATE:** _____ **EMAIL:** _____

SPOUSE'S NAME: _____ DAYTIME PHONE: _____

METHOD OF PAYMENT: CASH CREDIT CARD CARECREDIT OTHER _____

DENTAL INSURANCE INFORMATION:

PRIMARY:

Employee's name: _____

Social Security #: _____ DOB: _____

Employee ID #: _____

Employer: _____

Insurance carrier: _____

Claims address: _____

Phone: _____ Group #: _____

SECONDARY:

Employee's name: _____

Social Security #: _____ DOB: _____

Employee ID #: _____

Employer: _____

Insurance Carrier: _____

Claims address: _____

Phone: _____ Group #: _____

****WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?** _____

OTHER FAMILY MEMBERS IN OUR PRACTICE: _____

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for my insurance benefits.
I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
I understand that my dental insurance carrier or payer of my dental benefits may pay less that the actual bill for services.
I understand that I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payer.
I attest to the accuracy of the information on this page.

PATIENT'S (OR GUARDIAN'S) SIGNATURE _____ **DATE** _____

REGISTRATION

PATIENT'S NAME: _____
(Last) (First) (MI)

1. Purpose of visit: _____
2. Are you aware of a problem? _____
3. When was your last dental visit? _____
4. What was done at that time? _____
5. Previous dentists name: _____
   Address: _____ Phone number: _____
6. When was the last time your teeth were cleaned? _____
7. When was the last time you had dental x-rays? _____
8. Have you ever been diagnosed or treated for periodontal disease (gum disease)? YES NO
9. Have you made regular visits for your dental cleanings? YES NO
10. Have you had orthodontic treatment (braces)? YES NO
11. Do you snore? YES NO
12. Have you lost any teeth or have any teeth been removed? YES NO
13. Have they been replaced? YES NO
14. How have they been replaced? FIXED BRIDGE PARTIAL DENTURE DENTURE IMPLANT
15. Are you unhappy with the replacement? YES NO
16. Have you ever had an unpleasant dental experience? YES NO
    If yes, please explain: _____
17. Do you clench or grind your teeth? YES NO
18. Does your jaw click or pop? YES NO
19. Have you experienced any pain or soreness in the muscles or your face or around your ear? YES NO
20. Do you have frequent headaches, neck aches or shoulder aches? YES NO
21. Does food get caught in your teeth? YES NO
22. Are any of your teeth sensitive to: HOT COLD SWEETS PRESSURE
23. Do your gums bleed or hurt? YES NO
24. How often do you brush your teeth? _____ Floss? _____
25. What type of toothbrush do you use? SOFT MEDIUM HARD ELECTRIC
26. If you use an electric toothbrush, which one do you use? _____
27. Are any of your teeth loose, tipped, shifted or chipped? YES NO
28. How do you feel about your teeth in general? _____
    _____
29. Do you feel your breath is offensive sometimes? YES NO
30. Are you self-conscious about your smile? YES NO
31. Do you wish your teeth were whiter? YES NO
32. Do you dislike the shape of your teeth? YES NO
33. Do you have spaces between your teeth that you don't like? YES NO
34. Do you have old fillings or dental work that you don't like looking at? YES NO

Please list any other questions or concerns that you have about your mouth or oral health:

_____
_____

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S (OR GUARDIAN'S) SIGNATURE _____ DATE _____

DENTIST'S SIGNATURE _____ DATE _____

DENTAL HISTORY

Amy E. Schoening, D.D.S., P.C.
912 N. Fielder Road
Arlington, Texas 76012
(817) 275-4355

American Dental Association
Texas Dental Association

Academy of General Dentistry
Texas Academy of General Dentistry

Fort Worth District Dental Society
Academy of G.P. Orthodontics

OFFICE PAYMENT POLICY

1. Payment options include: ***Cash, Bank/Cashiers Check, MasterCard, Visa, American Express, Discover, CareCredit®***

2. We will accept assignment of insurance benefits for services; however any deductibles, or patient percentages, will be the responsibility of the patient at time of treatment. Please help us by providing accurate information regarding your insurance carrier, prior to your appointment. **Note:** *Since we are only able to 'estimate' your out of pocket expenses, you will be responsible for any balance that is unpaid by your insurance company. If insurance pays less than expected, you will be billed for any remaining balance after the insurance payment is received.*

3. Our office does not offer "payment plans." However under special circumstances when certain major treatment is needed, you may inquire with our Office Manager about paying ½ of your part on your first visit and the remaining ½ on your second visit. These arrangements are subject to review and must be approved prior to beginning treatment.

4. Although it is not a requirement, we do offer to file dental insurance as a "courtesy" to our patients. In return we ask that you please help us to continue to offer this benefit by taking care of any balances that may come back from insurance, as soon as you receive your statement.

5. **To avoid a $50.00 Cancellation Fee, we require a minimum 2 business days notice prior to all cancelled or rescheduled appointments.**

We take pride in doing our best to make your experience in our office a pleasant one. We will be happy to review your insurance benefits, your out of pocket expenses, or answer any questions that you may have, as accurately as possible. However, there are many different insurance companies with many different policies available. This makes it difficult for us to give you any exact information. When we review insurance benefits with you, it will be with the understanding that it is simply an estimate of your insurance coverage. We are not in a position to make any insurance guarantees, only to share with you what we have learned from your insurance company. If you have any questions or concerns regarding the financial aspect of your visit, please bring it to our attention before continuing with treatment. We hope that we can meet all of your dental needs today, and in the future.

Signature: _____ Date: _____

Pecan Park Dental
Amy E. Schoening, DDS & Stephanie Bangs, DDS
912 N. Fielder Road
Arlington, Texas 76012
(817)275-4355
www.pecanparkdental.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Social Security #: _____ Patient ID #: _____

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SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about you protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: CHERYL HOWE - Office Manager.

Telephone: (817) 275-4355 Fax: (817) 275 – 1241.

E-mail: SCHN325@aol.com.

Address: 912 North Fielder Road – Arlington, Texas 76012.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent. (See back to revoke)

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

With this form, I am also allowing consent for my treatment, payment activities, and health care operations to be discussed with the people I have listed below.

_____

_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM AFTER SIGNING IT.