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:

HOME: ___________________________________

WORK: ___________________________________

CELL: ___________________________________

EMERGENCY CONTACT:

NAME: ___________________________________

RELATIONSHIP: ___________________________

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)

DENTAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Is this your child's first visit to the dentist? YES NO
2. If not, how long since the last visit? ____________________
3. Were any x-rays taken when your child previously visited the dentist? YES NO
4. Previous dentists name: ____________________
   Address: ____________________ Phone number: ____________
5. Does your child eat between meals? YES NO
6. Does your child eat sweets, such as candy, soda pop, chewing gum? YES NO
7. When does your child brush his/her teeth? Upon rising? __________ After eating any food? __________
   Right after meals? __________ Before going to bed? __________
8. How does your child receive fluoride? Community water? _______ (level _____ ppm)
   Well water? ______ (level ____ ppm) Fluoride drops or tablets? _______ Fluoride rinse or gel? _______
9. Have any cavities been noted in the past? YES NO
10. Were any teeth (baby or permanent) removed by extraction? YES NO
    Was it suggested that the space be maintained? YES NO
    Was an appliance placed? YES NO
11. Have there been any injuries to teeth, such as falls, blows, chips, etc.? YES NO
    If so, please describe: ____________________
12. Has your child had any problems with dental treatment in the past? YES NO
13. Has anyone in the family, including parents, had orthodontics (braces)? YES NO
14. Has your child ever received a local anesthetic? YES NO
15. Has your child ever had sealants done on their teeth? YES NO
16. Does your child think there is anything wrong with his/her teeth? YES NO

MEDICAL HISTORY – CIRCLE THE APPROPRIATE ANSWER

1. Does your child have any health problems? YES NO
2. Is your child presently under a physicians care? YES NO Since when: ____________
   Please explain: ____________________
3. Name of Physician? ____________________ Phone: ____________
4. Is your child receiving any medications? YES NO What medications: ____________
5. Is your child allergic to penicillin, antibiotics or any other drugs? YES NO
6. Does your child have any other allergies? YES NO
7. Has your child ever had a serious illness? YES NO What illness? __________ When? __________
8. Has your child ever had surgery? YES NO What? __________ When? __________
9. Is surgery contemplated? YES NO

DOES YOUR CHILD HAVE A HISTORY OFANY OF THE FOLLOWING? (CIRCLE ALL THAT APPLY)

AIDS/HIV Positive
Allergies
Asthma
Behavioral/Learning Disorders
Cancer
Cerebral Palsy
Congenital Birth Defects
Diabetes
Dizziness/Fainting
Epilepsy
Frequent Headaches
Hepatitis
Hearing Loss
Heart Murmur
Heart Problems
Infections
Liver Problems
Lung Problems
Kidney Problems/Infection
Mental Retardation
Nervous Disorders
Rheumatic Fever
Severe/Prolonged Bleeding
Speech Impairments
Seizures
Tuberculosis (TB)
Vision Problems

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S (OR GUARDIAN'S) SIGNATURE ____________________ DATE ____________

DENTIST'S SIGNATURE ____________________ DATE ____________

CHILD DENTAL/MEDICAL HISTORY

Patient Privacy Directive

In our effort to comply with the Health Insurance Portability and Accountability Act (HIPAA), we need to be certain that we guard your privacy according to your wishes when it comes to your family, friends, and co-workers.

Please circle response to the following:

1. May we leave messages on a voice mail at home or on your cell to dicuss appointments or treatment ?
   YES NO
2. May we leave messages with or dicuss your appointments/treatments with your spouse ?
   YES NO
3. May we leave messages concerning your appointments with a co-worker or receptionist that regularly answers your calls ? **YES NO**
4. If you are over the age of 18, still living at home, may we discuss your appointments/treatment with your parent(s)/guardian ? **YES NO N/A**
5. If you are over the age of 18, may we discuss your appointments/treatment with your children ?
   YES NO N/A

Email Address: ______________________________

Please indicate your preferred method of contact:

- First Choice ☐ text ☐ email ☐ call and talk/voicemail
  work home cell ______________________
- Second Choice ☐ text ☐ email ☐ call and talk/voicemail
  work home cell ______________________
- Third Choice ☐ text ☐ email ☐ call and talk/voicemail
  work home cell ______________________

You must inform us in writing, of any changes in your directions. This record takes effect upon signing and dating this form. It will be kept in your file along with your acknowledgement of receipt of your Notice of Privacy Practices.
I acknowledge I have recieved of the "Notice of Privacy Practices"

Print Patient Name: ______________________________ D.O.B. __________

Signature (responsible party): ______________________________ Date: __________

Relationship to Patient: ______________________________

Office Rep: ______________________________ Date: __________

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 <u>before</u> continuing with treatment. We hope that we can meet all of your dental needs today, and in the future.

Signature: ______________________________ Date: ________________

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, ____, have received a copy of this
(Print Name)

Office's Notice of Privacy Practices.

____
(Please Print Name)

____
(Signature)

____
(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

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(This form is educational only, does not constitute legal advice, and covers only federal, not state, law in effect or proposed as of March 27, 2002. Subsequent law changes may require Form revision.)