Date _____ A B C

Confidential Patient Information

Patient's Name _____
Last First Middle

Preferred Name _____

Address _____
Street City State Zip

Home Phone _____ **Work Phone** _____ **Cell Phone** _____

Birth date _____ **Social Security #** _____

Drivers License Number _____ **EMAIL ADDRESS**_____

If Patient is a minor, give parent's or guardian's name _____

Whom may we thank for referring you to our office? _____

Confidential Responsible Party Information

Name _____ **Martial Status** _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ **Home Phone** _____**Work Phone** _____

Cell Phone _____

Previous Address (if less than 3 years) _____
Street City State Zip

Social Security # _____ **Birth date** _____ **Relationship to Patient** _____

Drivers License Number _____

Employer _____ **Occupation** _____ **# Years Employed** _____

Spouse's Name _____ **Relationship to Patient** _____
Last First Middle

Spouse's Employer _____ **Occupation** _____ **# Years Employed** _____

Spouse's Social Security # _____ **Birth date** _____ **Work phone** _____

Insurance Information

Policy Holder's Name _____ **& Soc. Sec. #** _____
Last First Middle

Insurance Company _____**Group #** _____**Union Local #** _____

Insurance Co. Address _____**Ins. Co. Ph.** _____
Street City State Zip

Policy Holder's Employer _____

Do you have dual coverage? No _____ **Yes** _____ **If yes:**

Policy Holder's Name _____ **& Soc. Sec. #** _____

Insurance Company _____ **Group #** _____ **Union Local #** _____

Insurance Co. Address _____**Ins. Co. Ph.** _____

Policy Holder's Employer _____

Emergency Information

Name of nearest relative not living with you _____

Complete Address _____
Street City State Zip

Phone _____ **Relationship** _____

I understand that where appropriate, credit bureau reports may be obtained.
Signature (Parent's signature if minor) _____

Updates (date & initial) _____

CONFIDENTIAL (for record and pretreatment evaluation)

HEALTH HISTORY

Patient's Name _____ Date of Birth _____ Date _____

Physicians Name _____ Address _____

Answer all questions by circling Yes (Y) or No (N)

1. Are you in good health?.....Y N
2. Has there been any change in your general health in the past year?.....Y N
3. Date of last physical exam _____
4. Are you now under a physician's care for a particular problem?.....Y N
5. Have you **ever** had any serious illnesses, operations or hospitalizations? If so, describe:.....Y N

   _____

   _____
6. Height _____ Weight _____
7. **DO YOU HAVE OR HAVE YOU EVER HAD:**
   - A. Congenital Heart Disease / Defect?.....Y N
   - B. Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High or Low Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker?).....Y N
     (Please underline all that apply)
   - C. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing, TB)?.....Y N
   - D. Seizures, Convulsions, Epilepsy, Fainting or Dizziness .....Y N
   - E. Bleeding Disorder, Anemia, Leukemia, Blood Transfusion? Do you bruise easily?.....Y N
   - F. Liver Disease (Jaundice, Hepatitis)? .....Y N
   - G. Kidney Disease? .....Y N
   - H. Diabetes?.....Y N
   - I. Osteoporosis/Osteopenia?.....Y N
   - J. Neurological conditions?Ex: Parkinsons, Huntingtons……..Y N
   - K. Thyroid Disease (Goiter / Hypo / Hyper)? .....Y N
   - L. Arthritis or any other inflammatory disease? .....Y N
   - M. Stomach Ulcers, Colitis or GI disorder? .....Y N
   - N. Glaucoma?.....Y N
   - O. Implants placed anywhere in your body? (Heart Valve, Hip, Knee) .....Y N
   - P. Has or had cancer?.....Y N
     *Type / When?_____
     *Treatment: Chemo / Radiation / Surgery?.....Y N
   - Q. Sinus or Nasal problems?.....Y N
   - R. Any disease, drug or transplant operation that has depressed your immune system?.....Y N
   - S. AIDS or tested HIV positive?.....Y N
   - T. Sexually transmitted disease?.....Y N
8. **ARE YOU USING ANY OF THE FOLLOWING:**
   - A. Antibiotics?.....Y N
   - B. Anticoagulants (Blood Thinners)?.....Y N
   - C. Aspirin or drugs such as Motrin, Aleve, Ibuprofen? Y N

All responses are kept confidential

- D. High Blood Pressure medications?.....Y N
- E. Steroids? (Cortisone, etc)……Y N
- F. Tranquilizers? …… Y N
- G Insulin or Oral Anti-Diabetic drugs?.....Y N
- H. Digitalis, Inderal, Nitroglycerin or other heart drug? Y N
- I. Are you taking or *have you ever taken* Bisphosphonates (Fosamax or Actonel for osteoporosis, or chemotherapy for multiple myeloma, etc.) ? .....Y N
- J. Please list any and all medications taken, including prescription medications, over-the-counter mediations, herbal or holistic remedies, vitamins or minerals:_____

_____

_____

_____

_____

9. **ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**
   - A. Local Anesthesia (Novocain, etc.)?.....Y N
   - B. Penicillin or other antibiotics?.....Y N
   - C. Sedatives, Barbiturates? .....Y N
   - D. Aspirin or Ibuprofen?.....Y N
   - E. Codeine or other pain killers?.....Y N
   - F. Latex or Metal Products? .....Y N
   - G. Other allergies or reactions? Please, list.....Y N

   _____

   _____
10. Do you smoke or chew Tobacco? .....Y N
    How much per day? _____
11. Is there any past or current history of Alcohol or Chemical Dependency or Emotional Disorder that may affect the care we provide you?.....Y N
12. Do you have any other disease, condition or problem not listed above that you think the doctor should know about?.....Y N
13. Do you wish to talk to the doctor privately about anything?.....Y N
14. **FOR WOMEN ONLY**
    - A. Are you Pregnant, or **<u>is there any chance</u>** you might be Pregnant?.....Y N
    - B. Are you nursing? .....Y N
    - C. **If you are using Oral Contraceptives**, it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills, after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible. I have had the opportunity to discuss my Heath History with my doctor.

Date _____ Signature of Person Completing Health History _____ Clinician's Initials _____

Annual Update: I have read my Health History and confirm that it adequately states past and present conditions.

Date	Exceptions or changes	Patient's Signature	Clinician' s Initials
Date	Exceptions or changes	Patient's Signature	Clinician's Initials

PATIENT'S NAME _____
Last First Middle Date of Birth

1. Purpose of initial visit _____
2. Are you aware of a problem? _____
3. How long since your last dental visit? _____
4. What was done at that time? _____
   _____
5. Previous dentist's name _____
   Address _____ Ph _____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE CORRECT ANSWER, PLEASE WRITE "DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? ……YES NO
8. Were dental x-rays taken? …….…... YES NO
9. Have you lost any teeth or have any teeth been removed? ……..…….. YES NO
   Why? _____
10. Have they been replaced? ……... YES NO
11. How have they been replaced?
    a. Fixed bridge _____ Age _____
    b. Removable bridge _____ Age _____
    c. Denture _____ Age _____
12. Are you unhappy with the replacement? …… YES NO
13. Would you like to know about permanent replacements? …….. YES NO
14. Have you had any complications with previous dental treatment? …… YES NO
    If yes, explain: _____
    _____
15. Do you clench or grind your teeth? ……... YES NO
16. Does your jaw click or pop? ……...YES NO
17. Have you experienced any pain or soreness in the muscles of your face or around your ear? ……...YES NO
18. Do you have frequent headaches, neck aches or shoulder aches? ……..YES NO
19. Does food get caught in your teeth? ……...YES NO
20. Are any of your teeth sensitive to: □ Hot? □ Cold? □ Sweets? □ Pressure?
21. Do your gums bleed or hurt? ……...YES NO
    When? _____
22. How often do you brush your teeth? _____ When? _____
23. Do you use dental floss? ……..… YES NO
    How often? _____
24. Are any of your teeth loose, tipped, shifted or chipped? …….. YES NO
25. Are you unhappy with the appearance of your teeth? ……..YES NO
26. How do you feel about your teeth in general? _____
    _____
27. Do you feel your breath is offensive at times? …….. YES NO
28. Have you ever had gum treatment or surgery? …… YES NO
    What? _____
    Where? _____
    When? _____
29. Have you had any orthodontic work? (Braces)……..YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry you strongly dislike? _____
31. Do you have any questions or concerns? …… YES NO

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S/ GUARDIAN'S SIGNATURE _____ **DATE** _____

DENTIST'S SIGNATURE _____ **DATE** _____

DENTAL HISTORY

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION ELECTRONICALLY

Patient Authorization for Release of Health Records to External Parties

1. I authorize The office of **Phillip F Sehnert DDS PA,** located at 501 West Main Street in Lewisville, TX, 75057, Phone: 972-420-0042 to disclose information from the health records of:

   _____

   (patient)

   Date of Birth: _____

☐ **I authorize the information to be disclosed to** the following Entities:

Referring Drs, Specialists, Insurance Companies and Billing Entities

☐ I authorize this information to be disclosed in the following ways:
Written/Photocopy/Paper, Verbal, Fax, Electronic Mail (email), Filing Insurance electronically, Electronic Billing

☐ I understand that the following types of protected health information may be disclosed as a result of the electronic communication:

My personal health information contained in my dental record
Video or electronic diagnostic images and X-Rays
Video recordings or still pictures of parts of my body that may include my face

I understand that I may withdraw or revoke my permission at any time. If I withdraw my permission, my information may no longer be used or released for the reasons covered by this authorization. However, any disclosures already made with my permission are unable to be taken back. I may revoke this authorization by notifying Phillip F Sehnert DDS PA in writing.

My treatment will not be based on the completion of this authorization form. The information to be released by this authorization may be re-released by the person or organization that receives it and may no longer be protected by Federal or Texas privacy regulations.

This authorization does not expire unless I specify another time: _____

I release the individual or organization named in this authorization from legal responsibility or liability for the disclosure of the records as authorized on this form. I understand that this authorization is voluntary and that I may refuse to sign it. I will be provided a copy of this signed authorization, if requested. A photocopy of this authorization is as valid as the original.

_____ _____
Signature of Patient (or Patient Representative) Date

_____ _____
Printed Name of Patient or Patient Representative Authority of Representative to Act for Patient (Relationship to Patient)

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Phillip F Sehnert, DDS
501 West Main Street
Lewisville, TX 75057
972-420-0042

I understand that, under the Health Insurance Portability & Accountability Act of 1966 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to aide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Information may be released to:_____
(eg: Other Doctors, Insurance Companies, Family Members)

Office use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date	Initials	Reason

Phillip F Sehnert, DDS, PA
501 West Main Street
Lewisville, Texas 75057
972-420-0042

FINANCIAL POLICY

Dear Patient:

Thank you for selecting us as your dental health care provider. Our office wants all of our patients to comfortably be able to afford the dental care they need. Our primary goal is that you receive the optimal treatments needed to restore and maintain your dental health. Therefore, if you have any questions or concerns about our financial policies, please do not hesitate to ask a member of our knowledgeable staff. Please remember, this office is always an "Out of Network" provider for any insurance plan.

Payment for services is due at the time services are rendered. We accept cash, personal checks, and for your convenience Mastercard, Discover, American Express, Visa and CareCredit. We also offer a 5% discount to those patients willing to pay for treatment in full and in advance of treatment with cash or check. As a courtesy to you, we will file your insurance and accept assignment of benefits as long as we have complete insurance information at the time of your visit.

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are **NOT** a party to that contract. Our financial relationship is with you, not your insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will and will not cover.

3. Fees for these services, along with unpaid deductibles and co-payments, are due at the time of treatment. We make every attempt to give you the most accurate **estimate** based on the benefit information your insurance company provides us.

4. If the insurance company does not pay your balance in full within 30 days, we will request that you contact your insurance company or Human Resource Division to aid in the process.

5. If the insurance company does not pay in full within 60 days, we will require you to pay the balance due with cash, personal check, Mastercard, Discover, American Express,Visa or CareCredit.

6. Balances older than 60 days may be subject to additional collection fees and interest charges of 1.5% per month (18%APR). Returned checks will have an additional fee of $30.00 added to the amount of the returned check and if unpaid, will be turned over to the Denton County Hot Check Division. **All** fees related to debt collection will be the responsibility of the patient or guardian.

7. New patients seen on an emergent basis will be required to pay for services in full. If you have insurance, it will be filed as a courtesy and you will be reimbursed according to your policy and plan provisions.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems to us so that we can assist you in the management of your account. Again, thank you for choosing Dr. Sehnert as your dental health care provider. We appreciate your confidence in us and the opportunity to serve you.

I understand that all balances are due at the time services are rendered unless one of the arrangements listed above have been made with our financial coordinator. I further understand that beginning with the first day of the month following your balance becoming sixty (60 days past due, a monthly charge of 1.5% (18% APR) will be assessed to any unpaid balance. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding account balances.

Patient's Signature:_____ Date:_____

Appointment Cancellation Policy

We strive to render excellent dental care to you and the rest of our patients. In an attempt to be consistent with this, we have an **Appointment Cancellation Policy** that allows us to schedule appointments for all patients. When an appointment is scheduled, that time has been set reserved for you and when it is missed, that valuable time cannot be used to treat another patient.

Our policy is as follows:

We require that you give our office **24 hours notice** in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office within the required time, this is considered a missed appointment. **A $50.00 cancelation fee** will be charged to you.

If you have any questions regarding this policy, please let our team know and we will be glad to address any questions you have.

We thank you for your patronage.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

Print Name: _____

Signature: _____

Date: _____