Larry D. Herwig, D.D.S.

8411 Preston Road, Suite 850 Dallas, TX 75225 (214) 361-1845

Thank you for choosing our office for your dental needs. Please provide us with your most current information to help ensure the quality of your care is excellent.

Basic Patient Information

Patient Legal Name: _____

Preferred Name: _____

Family Status: (circle one)

Married Single Child Other

Birth Date: _____

Please provide us with your two *best* contact numbers and circle the type:

Primary Phone: (_____) _____ - _____ Cell / Work / Home

Secondary Phone: (_____) _____ - _____ Cell / Work / Home / Spouse

Address: _____

_____

E-mail Address: _____

We are taking steps to becoming a paperless office, for future reference what is your preferred method of communication? _____

Employer/Occupation: _____

Who may we thank for referring you to our practice?

_____

Dental Insurance (if applicable)

Insurance Company: _____

Name of Insured: _____

Insured's Birth Date: _____

Insured's Member ID or Social Security #: _____

Group #: _____

Contact Phone #: (_____) _____ - _____

Patient's relationship to the Insured: (circle one): Self / Spouse / Child / Other

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Medical History

Within the past year, have there been any changes in your general health?

_____

Please indicate any medical conditions we should be aware of: (circle all that apply)

Acid Reflux/GERD	Epinephrine Allergy	High Blood Pressure	Radiation Trtmt
Anemia	Epilepsy	HIV	Rheumatism
Arthritis	Excess Bleeding	HPV	Seasonal Allergy
Asthma	Fainting	Jaundice	Sinus Problems
Blood Disease	Hay Fever	Joint Replmts	Sjrogen's Syndrome
Blood Thinners	Head Injuries	Latex Allergy	Stomach Issues
Cancer	Heart Attack	MVP	Stroke
Codeine Allergy	Heart Disease	Neurological	Sulfa Allergy
Diabetes	Heart Stent	Disorder	Thyroid Disturbance
Dizziness/Vertigo	Heart Murmur	Pacemaker	Tumors
Dry Mouth	Hepatitis	Penicillin Allergy	Ulcers

Any other allergies or conditions not listed above: _____

List any prescription or non-prescription medicines you are currently taking:

_____

Do you require antibiotic pre-med prior to dental visits?

- ☐ Yes
- ☐ No

Are you pregnant?

- ☐ Yes
- ☐ No

Who is your Medical Doctor and when was your last medical exam?

_____

In case of an emergency, who should we contact? (include name and phone number)

_____

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Dental History

When was your last visit to the dentist? _____

What is your reason for leaving your previous dental office?

_____

Please check any of the following problems that apply to you:

- ☐ Sensitivity (hot, cold, sweet)
- ☐ Tooth pain when chewing
- ☐ Headaches, jaw joint pain, neck pain
- ☐ Food packing or collection areas
- ☐ Broken teeth or fillings
- ☐ Grinding/clenching teeth, sleep apnea
- ☐ Bleeding, swollen, or irritated gums
- ☐ Loose or shifting teeth
- ☐ Bad breath or bad taste in your mouth

Do you smoke or use spit/chewing tobacco? For how long? How often?

_____

Do you have or have you had in the past any of the following:

- ☐ Dentures (partial or full)
- ☐ Dental Implants
- ☐ Braces
- ☐ Periodontal (gum) treatments
- ☐ Root Canal
- ☐ Oral Surgery (extractions)
- ☐ TAP/CPAP Device
- ☐ Night Guard

What kind of toothbrush do you currently use?

_____

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How often do you floss your teeth?

_____

What is the most important thing that we can do for you during your dental visit today?

_____

If you could change anything about your mouth, teeth, or smile what would it be?

- ☐ Make them Brighter
- ☐ Make them Straighter
- ☐ Close spaces
- ☐ Replace silver metal fillings with natural, tooth-colored fillings
- ☐ Repair chipped teeth
- ☐ Repair missing teeth
- ☐ Replace old crowns that don't match
- ☐ Have a smile makeover
- ☐ Other: _____

From the above question, which of these changes is most important to you?

_____

On a scale of 1 – 10, with 10 as the highest rating, please circle one:

How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Are there any other concerns or interests you have about your dental health that you would like the doctor to address during your visit?

_____

_____

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We are committed to providing you with excellent care and convenient financial options. The following is an explanation of our insurance policy and financial arrangements.

Payment Options

Payment in-full is due at the time services are rendered. For your convenience, we offer several payment options.

1. Cash, Check, Visa, MasterCard, and Discover
2. Pre-payment cash discount available over $500
3. Monthly payment plans available through 3rd party over $300

☐ By checking this box I acknowledge that I have read and agree to the content above.

Dental Insurance

We are happy to file all dental claims for you and provide an *estimate* in good faith, *not* a guarantee of payment, of what your insurance will cover for any dental treatment. You will be responsible for your estimated patient portion at the time services are rendered, as well as any amount that your insurance claim payment does not cover. Since Dr. Herwig is ***out of network*** for ALL insurance companies this amount may vary and a pre-determination of benefits can be sent upon request. Outstanding balances after 60 days will become the patient's responsibility.

Please know that dental benefits are based on the contract between your employer and the insurance company, not your actual dental needs. Our office is committed to helping maximize your benefits but our main concern is your dental health, which is not always comparable to your insurance benefits. Our financial coordinator is happy to assist you in knowing what will and will not be covered by your insurance.

☐ By checking this box I acknowledge that I have read and agree to the content above.

Missed Appointments

Once an appointment has been made, please remember that this time has been reserved specifically for you. In hopes of keeping an efficient schedule and respecting the time of each patient, we kindly request that you arrive promptly for all appointments and ask 48 hours notice to move an appointment. Cancellations or changes are sometimes unavoidable but should be made at least ***24 business hours*** prior to your appointment to avoid a cancellation fee.

☐ By checking this box I acknowledge that I have read and agree to the content above.

Financial Consent

I understand the office financial policy of *Larry D. Herwig, DDS* and agree to be fully responsible for total payment of all services rendered in this office.

Signature of Patient/Legal Guardian **Date**

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HIPAA Patient Privacy Agreement

The HIPAA privacy rule states that your protected health information (PHI) may be used and disclosed -with your permission- by *Larry D. Herwig, DDS* and any relevant 3rd parties that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, support the operation of the dentists practice and any other use required by law. This includes the disclosure of your health information in any form including written, spoken, or electronic. We agree to use appropriate safeguards to protect the privacy of patient information. A full HIPAA Privacy agreement is available upon request.

☐ By checking this box I acknowledge that I have read and agree to the content above.

Consent for Internet Communications

The HIPAA security rule requires that covered dentists who store patient information in electronic form maintain its confidentiality, integrity, and accessibility. Digital patient records and communications (text message/email) are increasingly common practice management tools, increasingly more effective and convenient. I grant my permission to *Larry D. Herwig, DDS* to upload, store, maintain, retrieve, and transmit my patient information confidentially to me or on my behalf. We assure our best efforts to use appropriate administrative, technical, and physical safeguards to avoid all electronic complications and prevent unwanted disclosure of any personal information and will alert you immediately should an issue arise.

☐ By checking this box I acknowledge that I have read and agree to the content above.

Record Release Agreement

Should the patient need records released to themselves or another healthcare provider, the signature below grants the ability for *Larry D. Herwig, DDS* to comply. This will only be done upon the request of the patient or legal guardian. Assuming a zero balance in our office, once a request has been made, we agree to have the requested information transferred within 30 days. This includes the transfer of digital records electronically and physical records via mail.

☐ By checking this box I acknowledge that I have read and agree to the content above.

General Photo Release

I hereby grant to *Larry D. Herwig, DDS* permission to use, re-use, or publish any dental-related photographs taken of me. I acknowledge that I will not be compensated in any way and that these photographs shall be **anonymous** and used specifically for the purpose of dental education and explanation of dental procedures. I release this right to Larry D. Herwig, DDS and discharge the office from any claims arising as a result of these photographs.

☐ By checking this box I acknowledge that I have read and agree to the content above.

I understand and agree to all of the terms and conditions on this page.

Signature of Patient/Legal Guardian **Date**