Dr. Sherry Church Dr. Michael Hoeppner Dr. George Metz III
Dr. Scott Reinecke Dr. Gary Skrobanek

11919 Culebra Rd. Bldg. 2
San Antonio, TX 78254
(210) 688-0332

Patient Information

Date: _____

Patient Name: _____ Preferred _____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Email: _____

Address: _____ Apartment #
Street

_____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Birth Date: _____ Social Security #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____

Address: _____
Street

Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Dental Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Insurance phone:

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last, First, MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Employer Name: _____

Address: _____
(Street, City, State, Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____ Phone:

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐Mailer ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other _____

Name of person or office referring you to our practice: _____

DENTAL HISTORY

Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? Scale of 1 to 10 (very) _____	☐	☐
2.	Have you had an unfavorable dental experience? _____	☐	☐
3.	Have you ever had complications from past dental treatment? _____	☐	☐
4.	Have you ever had trouble getting numb or reactions to local anesthetic? _____	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6.	Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS			
7.	Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8.	Have you ever whitened (bleached) your teeth? _____	☐	☐
9.	Are you self conscious about your teeth? _____	☐	☐
10	Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT			
11.	Do you / would you have any problems chewing gum? _____	☐	☐
12.	Do you / would you have any problems chewing bagels or other hard foods? _____	☐	☐
13.	Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
14.	Are your teeth crowding or developing spaces? _____	☐	☐
15.	Do you have more than one bite or do you clench (squeeze) to make your teeth fit together? _____	☐	☐
16.	Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
17.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
18.	Do you have tension headaches or sore teeth? _____	☐	☐
19.	Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE			
20.	Have you had any cavities within the past 3 years? _____	☐	☐
21.	Do you have a dry mouth? _____	☐	☐
22.	Are any teeth sensitive to hot, cold, biting or sweets? _____	☐	☐
23.	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth? _____	☐	☐
24.	Do you avoid brushing any part of your mouth? _____	☐	☐
25.	Do you feel or notice any holes (i.e. pitting) in your teeth? _____	☐	☐
GUM AND BONE			
26.	Have you ever been diagnosed or treated for periodontal (gum) disease? _____	☐	☐
27.	Have you ever experienced gum recession? _____	☐	☐
28.	Is there anyone with a history of periodontal disease in your family? _____	☐	☐
29.	Do your gums bleed when brushing, flossing or eating? _____	☐	☐
30.	Are your teeth becoming loose? _____	☐	☐
31.	Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
32.	Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ any other medications _____		
3. heart problems_____	☐	☐
4. heart murmur _____	☐	☐
5. rheumatic fever _____	☐	☐
6. scarlet fever _____	☐	☐
7. high blood pressure _____	☐	☐
8. low blood pressure_____	☐	☐
9. a stroke_____	☐	☐
10. artificial prosthesis (i.e. heart valve or joints)_____	☐	☐
11. anemia or other blood disorder_____	☐	☐
12. prolonged bleeding due to a slight cut _____	☐	☐
13. emphysema_____	☐	☐
14. tuberculosis _____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. snoring, sinus)_____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid or parathyroid disease _____	☐	☐
21. hormone deficiency_____	☐	☐
22. high cholesterol _____	☐	☐
23. diabetes _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries_____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic problems_____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. venereal disease _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / drug dependency _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your general health _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. subject to frequent headaches _____	☐	☐
52. a smoker or smoked previously _____	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Lost Creek
DENTAL

Dr. Michael Hoeppner *Dr. George Metz III*
Dr. Scott Reinecke *Dr. Gilberto Tostado*

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(210) 688-0332

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

USES AND DISCLOSURES

Our office must provide you, the patient, a description and at least one example of the types of uses and disclosures that our office is permitted to make for the purpose of treatment, payment, and health-care operations (all uses and disclosures, by the way, which are permitted by law without authorization of the patient).

Treatment- Our office will use and disclose your protected health information (PHI) for purposes of treatment, meaning the provision, coordination and management of your health care and related services. For instance, we will use and disclose your health information to coordinate benefits with a third party payer, or for consultation between our office and a specialist if required for your care.

Payment- Our office will use and disclose the minimum necessary amount of your PHI to obtain payment for services rendered. For example, our office may share your treatment plan with your insurer to determine the coverage allowed by your benefits plan.

Health-care Operations- Our office will use and disclose the minimum of your PHI for health-care operations, such as business planning and development that involves cost management and planning-related analyses related to managing and operating the entity, including formulary development or improvement of methods of payment or coverage policies.

Friend, family and personal representatives- We may disclose your health information to a family member, friend, or personal representative to the extent necessary to help you with your health care or with payment for your health care. Before your PHI is disclosed to these individuals, we will provide you with the opportunity to object. If you are not present or if in the instance you are incapacitated or in a state of emergency, your medical information will only be disclosed based upon our professional judgment. Our professional judgment and experience with common standards of care may be used to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of PHI. PHI about you may be disclosed to notify or assist in notifying a person involved in your care.

Appointment Reminders-We may use or disclose the minimum necessary amount of your PHI to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief-We may use or disclose your PHI to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit-We may use or disclose your health information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law;
- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report domestic violence, neglect, and abuse;
- To health oversight agencies;
- In response to court administrative orders and other lawful processes;

- To appropriate law enforcement officials in pursuit of subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on out premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- In connection to certain research activities;
- To federal military officials for intelligence, counterintelligence, or matters of national security;
- To correctional facilities in regards to inmates;
- As authorized by state worker's compensation laws;

General Authorization Statement-For any other purposes not stated in this notice, our office will not use or disclose your PHI without your prior written authorization.

PATIENT RIGHTS

The Patient-You have the right to inspect or obtain copies, a summary or an explanation of your PHI, with limited exceptions. Our office requires you to submit such requests in writing to our privacy director. Requests in writing may be made to our address at the bottom of this notice. This request must be acted upon no later than 30 days after receipt of your request, unless the PHI is not maintained or accessible to our office site. If necessary our office will inform you within 30 days if a delay occurs. Our office has the right to charge you a cost based fee for the provision of any copies provided. Please contact us for any information on fees associated with providing your copies.

Accounting of Disclosures-You have the right to receive a list of instances in which we our business associates disclosed your PHI over the past 6 years (but not before April 14, 2003). Disclosures to carry out treatment, payment and health-care operations, as authorized by you, for those considered to be of public benefit as written above, or any disclosure before April 14, 2003 are exempted from this accounting. If an accounting is requested more than once in a twelve month period, a reasonable, cost-based fee may be charges for these additional requests.

Restrictions-You have the right to request restrictions on certain uses and disclosures of your health information, though our office is not required to grant such requests. Your request is not binding unless given in writing.

Confidential Communications-You have the right to request, and our office must accommodate reasonable requests to receive confidential communications of PHI from our office by alternative means or locations. Your request must be made in writing and specify the alternative means while providing an explanation of how payment will be rendered under your request.

Your Authorization-You may give us written authorization to use your PHI or to disclose it to any one for any purpose. If authorization is given you may revoke it at any time. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

Right To Amend-You have the right to request, in writing that we amend in PHI. Our office, however, may deny such request if we determine that the PHI was not created by our office, is not part of the designated record set, the information is not available for access to you, or the current information is accurate and complete.

QUESTIONS AND COMPLAINTS

Patients may file a complaint with our office and the U.S. Department of Health and Human Services Secretary if they believe their privacy rights have been violated. Complaints must be filed within 180 days of when you knew or should have known that the alleged violation occurred. To do so, please request a complaint form from our privacy director. Please be assured, patients who file complaints will not be retaliated against for doing so. We support the privacy of your health information.

Our office is required by law to maintain the privacy of your PHI and to provide you with notice of our legal duties and privacy practices. Our office is required to abide by the terms of the notice and make the new notice provisions effective for all PHI that we maintain.

Effective: April 14, 2003

Lost Creek
DENTAL

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Acknowledgement of Privacy Policy

I acknowledge that I received and reviewed the Privacy Policy Notice for the office of Lost Creek Dental.

_____ Date: _____

Signature of patient, parent, or guardian

In the case you do not agree to sign this form, our office must indicate why you decline to do so. Reason for patient, parent, or guardian's refusal:

_____

_____

Privacy Director's signature: _____

Date: _____

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Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____

Signature of patient, parent or guardian

Lost Creek
DENTAL

FINANCIAL POLICY

As we enter this doctor-patient relationship, we agree to provide quality healthcare at a fair and reasonable price. You in turn, agree it is your obligation to be prepared to pay at the time of service and to understand the benefits of your insurance. We want to explain our financial policy to you so there are no unpleasant surprises.

- **Co-payments, deductibles and/or coinsurance are due at the time of service.** We accept Cash, Personal Check, Visa, MasterCard, Discover, American Express and Care Credit. If you are not prepared to pay the required amount, we are required to reschedule the appointment. The estimated financial responsibility for scheduled services will be due at the time services are provided unless earlier arrangements have been made. Any remaining balance after your health plan pays will be due upon receipt of a statement. If insurance coverage cannot be verified prior to the appointment, the account will be notated as private pay and payment will be due in full. *Account balances over* 90 *days with no payment activity will be reported to the credit bureau.* **Initials** _____

- **Your insurance policy is a contract between you and your insurer. Do not assume your policy covers everything or pays 100%. It is your responsibility to know what your policy covers and what it does not. We cannot guarantee your benefits.** Any item deemed "non-covered" by your insurance carrier will be your financial responsibility. Any disputes about payment must be resolved between you and your insurance company. Failure to provide accurate insurance information within 3 days from the date of service will result in the balance becoming your financial responsibility. **Initials** _____

- **As a courtesy to you, we will file primary participating insurance for you.** Please bring your insurance card with you to every visit. I understand that all remaining balances are my responsibility to satisfy prior to additional services being rendered. **Initials** _____

- **A $35.00 fee will be assessed for all returned checks. A $50.00 fee will be added to your account each time a cancellation is made without providing 24 hours notice.** We do understand that emergencies do happen, and we will take that in to consideration if the need arises. **Initials** _____

- A treatment plan is only an estimate. I understand I am responsible for all charges; in the case of insurance, I understand I am responsible for my portion of the charges and any charges my insurance company deems "not covered". If my insurance company uses an "alternate benefit" I understand I will be responsible for the difference. **Initials** _____

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice at any time.

_____ _____
Responsible Party Printed Name Date

_____
Responsible Party Signature