

# WELCOME!



## Patient Information

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

(Please Print)

Name \_\_\_\_\_ Date \_\_\_\_\_ SS/HIC/Patient ID# \_\_\_\_\_  
First Middle Initial Last

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex:  Female  Male Birthdate \_\_\_\_\_ E-mail \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Do you prefer to receive calls at:  Home  Work  Cell  No Preference

Married  Widowed  Single  Minor  Separated  Divorced  Partnered for \_\_\_\_\_ years

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Spouse or parent's name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Whom may we thank for referring you to us? \_\_\_\_\_

Person to contact in case of emergency \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

## Responsible Party

Name of person responsible for this account \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

## Insurance Information

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

DO YOU HAVE ADDITIONAL INSURANCE?  No  Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date employed \_\_\_\_\_

Name of employer \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Group # \_\_\_\_\_ Employer # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_ Max. annual benefit? \_\_\_\_\_

CONFIDENTIAL

# Dental History

Name \_\_\_\_\_ Age \_\_\_\_\_ Date of last exam \_\_\_\_\_  
 Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_  
 Reason for today's visit \_\_\_\_\_  
 How often do you brush? \_\_\_\_\_ How often do you floss? \_\_\_\_\_

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

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to heat            |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

# Medical History

Physician \_\_\_\_\_ Date of last visit \_\_\_\_\_

Please list all medications you are currently taking: \_\_\_\_\_

Allergies: \_\_\_\_\_

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> AIDS                    | <input type="checkbox"/> Congenital Heart Lesions | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments     | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent        | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up blood           | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes                 | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy                 | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting                 | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Bleeding Abnormally     | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Headaches                | <input type="checkbox"/> Nervous Problems      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Heart Murmur             | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Problems           | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Chemotherapy            | Describe _____                                    | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia               | <input type="checkbox"/> Respiratory Disease   |   |

Have you ever taken any of these medications?

- |                   |  |                                    |                                   |                                |
|-------------------|--|------------------------------------|-----------------------------------|--------------------------------|
| Diet Medications: | <input type="checkbox"/> Dexfenfluramine | <input type="checkbox"/> Fen-phen  | <input type="checkbox"/> Pondimin | <input type="checkbox"/> Redux |
| Blood Thinners:   | <input type="checkbox"/> Coumadin        | <input type="checkbox"/> Warfarin  |                                   |                                |
| Other:            | <input type="checkbox"/> Levoxyl         | <input type="checkbox"/> Synthroid |                                   |                                |

# Certification and Assignment

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company(ies)

and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

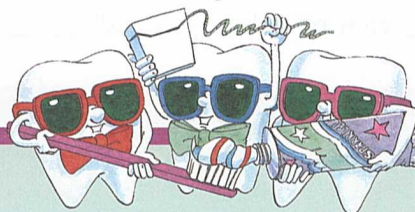
The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

\_\_\_\_\_  
 Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
 Relationship to Patient



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## NOTICE OF PRIVACY PRACTICES

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THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

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### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you, or to family and friends you approve.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. You also have the right to request restrictions on disclosure of PHI (Personal Health Information), or alternative means of communication to ensure privacy.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law or national security activities.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

**Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

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### PATIENT RIGHTS

**Access:** You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

**Amendment:** You have the right to request that we amend your health information.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services.

A Privacy/Contact Officer has been designated for this office. Please ask our front desk personnel and they will direct you to the Privacy/Contact Officer.

### PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT FOR NECESSARY USE OF PERSONAL HEALTH INFORMATION

Print Patient's Name \_\_\_\_\_

Date \_\_\_\_\_

I, \_\_\_\_\_, have received  
(Signature of Patient or Parent or Legal Guardian)

a copy of this office's NOTICE OF PRIVACY PRACTICES as required by federal law.

I, \_\_\_\_\_, consent to the use and disclosure of  
(Signature of Patient or Parent or Legal Guardian)

my personal health information by your office during Treatment, Billing/Payment and Healthcare Operations as outlined in the Notice of Privacy Practices.



Dr. Keri Zayed, DDS  
Dr. Stacy Sheinbein-Garner, DDS

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This document presents an abbreviated review of the current Texas Occupations Codes, as they apply to Ethics and Law in Dentistry. The information contained in this document was derived from the Texas Codes. Those who wish to obtain a copy of this document may request a photo copy from the front desk. Any additional questions may be addressed to The Texas State Board of Dental Examiners (TSBDE) at 333 Guadalupe, Tower 3, Suite 800 Austin, TX 78701 or by email to [information@tsbde.state.tx.us](mailto:information@tsbde.state.tx.us)

**Patient Records, Formats, HIPPA Regulations**

A patient's dental record is a legal document and, as such, should be developed within the guidelines outlined by Texas Law.

All dental records and other documents involving patient care are considered to be the property of the owner, dentist and Texas Capital Dental. As per HIPPA, a dentist shall furnish copies of dental records to a patient who requests their records. The copies of radiographs shall be furnished within thirty (30) days of the date of request. Unless there is an unforeseen emergency, then an additional 30 day extension may be granted in writing by the dentist. These laws apply to the dentist who is the owner of the practice, in this case Texas Capital Dental. Further, he/she is responsible for the dental records when treatment is rendered by other dental health care workers, i.e. hygienists, visiting dentists, or associates within the practice. When a patient requests their records, the dentist may charge a nominal fee for the duplication of radiographs.

A dentist providing copies of the patient's dental record may charge a fee for copying. The fees charged for duplicating the radiographs, which if copied by a radiograph duplicating service, may be equal to the actual cost verified by the invoice. The cost of duplication of radiographs must not exceed the following costs: full mouth radiograph series, \$15.00; panoramic radiograph, \$15.00; lateral cephalometric radiograph, \$15.00; single extra-oral radiograph, \$5.00; single intra-oral radiograph, \$5.00. Copies need not be released until payment of copying costs has been made. However, a dentist may withhold the record from the patient if there is an unpaid balance or disputed fee. SBDE 108.8(g).

HIPPA states that patient's dental records must not be released without written authorization from the patient. This law prohibits other dentists from reviewing a patients' record unless they are directly involved in the care of the patient.

**AGREEMENT**

"I have read and understand the above laws and regulations. By signing below, I acknowledge responsibility and agree to the terms as written above."

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient



Dr. Keri Zayed, DDS  
Dr. Stacy Sheinbein-Garner, DDS

**NOTICE TO INSURANCE PATIENTS**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I AM RESPONSIBLE FOR MY BALANCE IF ANY OF THE FOLLOWING OCCURS:

- A. The treatment goes over my yearly maximum.
- B. My insurance company denies any treatment.
- C. I am not eligible for insurance.
- D. I prevent or delay payment by not complying with requests for insurance forms or signatures.
- E. I do not complete my treatment and it results in non-payment by the insurance company.
- F. Lab costs are incurred due to missing appointment.
- G. I received my insurance check and do not send it to your office.

I hereby authorize payment directly to the above named dentist of the group insurance benefits otherwise payable to me but not to exceed the charges shown above. I understand that I am financially responsible for any charges not covered by this authorization. I hereby accept the foregoing treatment plan and authorize release of any information relating to this claim.

I have read and understand my obligations in acceptance of my dental insurance as payment.

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Name of Responsible Party (print)

\_\_\_\_\_  
Witness (Office Personnel)

\_\_\_\_\_  
Date



Dr. Keri Zayed, DDS  
Dr. Stacy Sheinbein-Garner, DDS

**Financial Policy**

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Thank you for choosing Texas Capital Dental as your dental care provider. We are committed to quality patient care. The following is a statement of our Financial Policy, which we want you to fully understand prior to treatment.

Please understand that payment of your bill is considered a part of your treatment plan. If you are unable to pay in full today, please inform the front desk personnel so that we may discuss the financing options available to you.

We accept cash, checks, and all major credit cards except for American Express.

**Full payment is due at time of service.**

REGARDING INSURANCE

We may accept assignment of insurance benefits on your first visit to Texas Capital Dental. This means that your insurance company will pay us instead of you. *However, your insurance policy is a contract between you and the insurance company. We have no control over the insurance company's decisions and the amount they pay.*

Before filing a claim on your behalf, we will attempt to verify your coverage and calculate your deductible and co-payments as accurately as possible. All deductibles and co-payments are due at the time of service unless prior arrangements have been made.

You should be aware that your insurance company will not guarantee payment over the telephone. We will now know the exact amount they will cover until they respond to the claim. Regardless of what your insurance company decided to pay; you remain fully responsible for the payment of your bill. Once payment is received on your claim, we will send you a bill for any balance remaining on your account.

AGREEMENT

"I have read and understand the above Financial Policy. By signing below, I acknowledge responsibility and agree to the terms written above."

\_\_\_\_\_  
Signature of Responsible Party

\_\_\_\_\_  
Name of Responsible Party (print)

\_\_\_\_\_  
Witness (Office Personnel)

\_\_\_\_\_  
Date