Stephen M. Sherwood, DDS, PLLC
6500 N MoPac
Bldg 2, Suite 2206
Austin, TX 78731
(512)454-6936 insuranceandbilling@yahoo.com (512)454-0437fax

Patient Information

Patient Name: ______________________________________ Birth Date:__________
Last First MI

☐ Male ☐ Female ☐ Child ☐ Adult **e-mail**______________________

Phone Home:________________ Work: ____________Ext: _____Cell: ______________

Address: ____
Street Apartment #

____
City State Zip Code

Patient Health Information

Date of Last Dental Visit:________________ Reason for this visit:____________________

Has your child ever had any of the following? Please check those that apply:

☐ AIDS
☐ Autism
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ Cerebral Palsy
☐ Diabetes
☐ Developmental Delays
☐ Excessive Bleeding
☐ Eye Disease
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Medication Allergies___________
☐ Mental Disorders
☐ Neurological Disorders
☐ Pregnancy
Due Date ____________
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Seizure Disorder
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis
☐ OTHERS:___________
____

- Does your child have any other health problems or special needs not described above? ☐ Yes ☐ No
  If yes, please explain:____
- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Name of Pediatrician/Physician:______________________________ Phone:______________
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Is your child now under the care of a physician or specialist for a specific illness? ☐ Yes ☐ No
  If yes, please explain:____
- Is your child currently on any medications? If yes, what medications and for what condition?
  ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment.

____ Date:________________
Signature of patient, parent or guardian

Dental History

Former Dentist:______________________________ Phone Number:______________________

Date of Last dental visit:__________________________ Date of Last dental X-Rays:______________

Circle all that apply:
Bad Breath Bleeding Gums Grinding Teeth Loose Teeth or Broken Fillings Sensitivity to Cold and/or Hot

How often do you FLOSS? ________________ How often do you BRUSH? ____________________

Referral Information

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

☐ Dental Office ☐ Yellow Pages ☐ Newspaper ☐ School ☐ Work ☐ Other ____________________

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

Responsible Party Information

Name:____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ________________________

Social Security#:______________________________ Birth Date:___________________________________

Phone Home:________________ Work:___________________ Ext:_______ Cell:___________________

Address: ____
Street Apartment #

____
City State Zip Code

Responsible Party Employment Information

Employer Name:__________________________________ Occupation:____________________________

Address:____
Street City State Zip Code

Primary Dental Insurance Information

Name of Insured: ___________________ _____ _________________ Phone Number ___________________
Last First MI

Insured's Birth Date:_____________ _______ ___ Insured's Social Security Number:______________________

Subscriber ID #: _____________________________________ Group #:______________________________

Insured's Address:____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Child ☐ Other____

Insurance Plan Name and Address: ____

Insurance Plan Phone Number: ___________________________

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 done so with the understanding that the parents 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 30 days.
I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days 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 the stated value of said services to said Doctor, or his assignee, at the time services are rendered. I further agree that the reasonable value of said services shall be as agreed to before treatment was rendered

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

____ Date: ___________ Relationship to Patient: ___________________
Signature of guarantor of payment/responsible party

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HIPAA Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of our practice (e.g. pharmacies and hospitals).

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations. I understand that if I exercise this right, then there can be no communication about the patient with anyone, under any circumstances. Even in extreme circumstances, all information would remain confidential, regardless of need.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the request date will be allowable and agreeable.

____
Print Patient Name

________________________________ ______________
Responsible Person's Signature Date

____
Relationship to Patient

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Notice of Office Policies

Our office hours are Monday 9 – 5. Tuesday – Thursday 8am-5pm. We are closed from approximately 12:45pm-1:45 for lunch. We do not answer phones after 4:30 or at any time Friday, Saturday or Sunday. We do not see patients on Fridays, except when performing surgery.

For the consideration of all our patients, your appointment will need to be rescheduled if you arrive more than 10 minutes late.

If you are unable to keep a scheduled appointment, please be sure to give us appropriate notice of at least 24 hours, this does not include Friday's or the weekend, as we are closed. When calling to cancel or reschedule your appointment, please be sure that you speak directly with the scheduling coordinator. Your account will be charged a fee of $30.00 for hygiene, $60.00 for treatment, or $115.00 for sedation appointments that are not given proper cancellation notice.

Patients that have had 3 no shows or late cancellations, appointments will not be rescheduled.

Patient payment estimates are due at the time of your appointment. Please ask to speak with the financial coordinator regarding available payment arrangements so that the best option can be chosen prior to your reserved appointment date.

Thank you for choosing our office for your child's dental needs. We look forward to a long and happy relationship with our patients and their families.

____

Please Initial here

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In order to better serve the families that trust and rely on us, we would like to ask you a few questions about how you came to choose our office. If you could take a moment to fill this out and email it back we would greatly appreciate it.

What sources did you use to make your choice to come to Sherwood Pediatric Dentistry?

Did you see an ad? If yes, where?

Did you pass our building?

Did you talk to your friends and neighbors? If yes, who? (Please list all, as they will receive a thank you gift)

Did you seek us out on the internet?

What internet sources did you use?

Have you visited our website?

Do you have feedback on improvements that could be made to the website?

Thank you so much for being part of this research!