Smiles
By German Design

NEW PATIENT INFORMATION			
Patient's Name:			Today's Date:
Preferred Name:	Male / Female		
Birthdate:	Age:		SS#
Mailing Address:			
City:	State:		ZIP Code:
Home#		Work#	
Cell#		Other#	
May we contact you by email? Yes / No	E-mail:		
Best time and number to reach you:			
May we contact you by text message? Yes / No		Referred by:	
Employer:		How long?	Occupation:
City:	State:		Zip:
PERSON ULTIMATELY RESPONSIBLE			
Name:		Driver License #:	
Billing Address:			Work Phone:
City:	State:		SS#:
Relationship:		Payment method: Cash / Check / Credit Card	
_____ I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.			
PRIMARY DENTAL INSURANCE			
Company Name:		Phone:	
Address:			Insured's SS#:
City:	State:		Zip:
ID#:	Group #(Plan, Local or Policy#)		
Insured's Name:	Relationship:		DOB:
Insured's Employer:			
SECONDARY DENTAL INSURANCE			
Company Name:		Phone:	
Address:			Insured's SS#:
City:	State:		Zip:
ID#:	Group #(Plan, Local of Policy#)		
Insured's Name:	Relationship:		DOB:
Insured's Employer:			
IN THE EVENT OF AN EMERGENCY			
Contact:	Relationship:		Best Phone #:
2nd Phone #:	Who is your medical doctor?		M.D.'s Phone#:

Smiles by German Design
134 North Maple Street. Muenster, TX 76252
940.759.2303

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Medical History

Name: _____ DOB: _____ Date: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

1. Have you ever been hospitalized or had a major operation? YES/ NO

_____

2. List ALL Medical Doctors and Phone numbers:

_____

_____

3. Have you ever had cancer, chemotherapy or radiation? If yes, when and what area of your body? YES/ NO

_____

4. Are you taking any medications, pills or drugs? YES/ NO

_____

_____

5. Do you take any blood thinners? _____
6. Do you have any Artificial Joints? If yes, please explain. YES/ NO

_____

7. Do you or have you ever taken a bone hardener? If yes, which one? Was it a pill or injection? YES/ NO

_____

8. Do you have pain in your jaw joints? YES/ NO
9. Do you use tobacco? How much per day? YES/ NO

_____

10. Do you use controlled substances? YES/ NO

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Women: Are you…

1. Pregnant/ Trying to get pregnant? YES/ NO
2. Nursing? YES/ NO
3. Taking Oral Contraceptives? YES/ NO

Are you allergic to any of the following?

1. Aspirin	YES/ NO	5. Codeine	YES/ NO
2. Metal	YES/ NO	6. Sulfa Drugs	YES/ NO
3. Penicillin	YES/ NO	7. Acrylic	YES/ NO
4. Latex	YES/ NO	8. Local Anesthetics	YES/ NO

Are you allergic to anything not listed above? Please specify. YES/ NO

_____

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Do you have, or have you had, any of the following? Please circle.

Disorders of the Blood:

1. AIDS/ HIV Positive
2. Blood Disease
3. Blood Transfusion
4. Hemophilia/Blood Clotting
5. Hepatitis A
6. Hepatitis B or C
7. Excessive Bleeding
8. Anemia

Disorders of the Heart:

1. A-Fib
2. Heart Attack
3. Angina
4. Heart Murmur/Irregular Heartbeat
5. Heart Pacemaker
6. Heart Bypass
7. Chest Pains
8. Congenital Heart Failure
9. High Blood Pressure
10. Low Blood Pressure
11. High Cholesterol
12. Mitral Valve Prolapse

Disorders of the Lungs:

1. Asthma/ Hay Fever
2. COPD
3. Emphysema/Easily Winded

Disorders of the Brain:

1. Stroke
2. Alzheimer's/Dementia
3. Convulsions/Seizures
4. Depression
5. Drug Addiction
6. Fainting/ Diziness
7. Psychiatric Care

Disorders of the Body:

1. Diabetes
2. Anaphylaxis
3. Arthritis/Gout
4. Artificial Joint
5. Cancer/ Leukemia
6. Radiation Treatments
7. Bruise Easily
8. Cold Sores/ Fever Blisters
9. Excessive Thirst
10. Frequent Cough
11. Frequent Diarrhea
12. Frequent Headaches
13. Genital Herpes
14. Glaucoma
15. Herpes
16. Hives/Rash
17. Kidney Problems
18. Liver Disease
19. Osteoporosis
20. Thyroid Disease
21. Recent Weight Loss
22. Renal Dialysis
23. Rheumatism
24. Scarlet Fever
25. Shingles
26. Sickle Cell Disease
27. Sinus Trouble
28. Intestinal Disease
29. Tonsillitis
30. Tuberculosis
31. Tumors/Growths
32. Ulcers
33. Venereal Disease
34. Yellow Jaundice

Have you ever had any illness not listed above? If yes, please explain. YES/ NO

_____

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ATTENTION ALL INSURANCE PATIENTS:
PLEASE READ THIS PAGE CARFULLY IN ITS ENTIRETY!

AUTHORIZATION TO RELEASE
AND
AUTHORIZATION OF ASSIGNMENT OF BENEFITS

We strongly feel that all patients deserve the very best dental care that we can provide. Furthermore, we feel that everyone benefits when definitive financial arrangements are agreed upon. Accordingly, we have prepared this material to acquaint you with our policy.

OUR PROFESSIONAL SERVICES ARE RENDERED TO YOU, NOT THE INSURANCE COMPANY. THEREFORE, PAYMENT FOR TREATMENT IS YOUR RESPONSIBILITY.

Please read and sign the following:

- I authorize SBGD to release or receive any information necessary to expedite my insurance claims.
- I hereby authorize SBGD to bill my insurance company directly for their services.
- I authorize payment directly to SBGD of any insurance benefits otherwise payable to me.
- In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to SBGD for which these fees are payable.
- I understand that there are provisions and exclusions in my dental plan that may prevent payment for my procedures. I also understand that my insurance may not inform the provider of these provisions and exclusions upon benefit verification.

I understand that it is up to me to inform SBGD of my insurance eligibility, waiting periods and benefits. I also understand that this office cannot guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by the staff at SBGD is **NOT** a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to be paid at that time.

_____ _____

Patient Signature Date

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Financial and Appointment Policy

The following policy is designed to ensure clear expectations and a collaborative care experience.

Appointments/Reminders:

- The appointment times you receive in our office are times reserved specifically for you and should be attended at all cost.
- **We require a 24 hour cancellation/reschedule notice. A $50 fee will be charged directly to the patients account without this notice. A $150 fee will be charged to the account if scheduled with a specialist. After 3 cancelled/no-show appointments, you are subject to termination from the practice, at the discretion of the doctor.**
- We do understand that emergencies arise, but please be considerate of your fellow patients and the doctors time.
- Our team does our best to communicate with our patients through phone, text and email. Through these services, you will also receive confirmations and reminders for all appointments. You may opt out of these reminders, but doing so will remove you from all communication.

Insurance:

- Our office understands the value of insurance benefits to our patients and will file claims to the insurance company as a courtesy to our patients. We will *estimate* your deductible, benefits and portions to be covered by your insurance, but our estimates are subject to final approval by your insurance company and could therefore change the amount owed to our office.
- **Your insurance policy is a contract between you, your employer and your insurance company. Our office is not a party to that contract.** You are ultimately responsible to know the coverage, exclusions and limitations of your policy. If you wish for us to bill your insurance as a courtesy, your complete insurance information must be presented prior to services being provided.
- You are responsible for paying your estimated out of pocket portion of your treatment at the time services are rendered. We will file your insurance, payable directly to our office, but you are ultimately responsible for 100% of treatment costs.
- In some cases, insurance companies will reimburse the subscriber, rather than the office. In these instances, you are required to bring the check to the office upon receipt. Further, a card number is required to hold on file and will be charged after 90 days if insurance payment is not received.
- Our practice is committed to providing the best treatment for our patients possible and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance companies arbitrary determination of their usual and customary rates.

Responsible Parties:

- It is our office policy that whoever brings a patient to be seen is the responsible party for payment.
    - If someone other than a child's parent brings them to an appointment, or a young adult comes alone, it is determined that the individual in office is responsible for payment at the time of service.
    - We understand that a divorce decree will sometimes name one person responsible for dental bills; however, this is a matter that should be resolved outside of the office so that payment can be made at the time of service.

Payment Options:

- We accept cash, check, Discover, American Express, VISA and Mastercard
- A $25 returned check fee will apply to all accounts
- Effective 8/1/2026, a 3% finance charge will apply to ALL credit transactions (this does not apply to debit card transactions)
- Outside financing is available upon request and approval
    - Care Credit: 6-12 month no interest payment option.
    - Proceed Finance: option for long term payment of treatment through 3rd party vendor.
    - Cherry Finance: option for short term or long term payment through 3rd party vendor

Deposits/Prepayments:

- There are treatment instances in which patients will be required to make pre-payments for services rendered in office. These typically apply to services in which patients will be sedated for treatment and require a driver to and from the office. These instances will be communicated verbally by office staff and are subject to the provisions of the office depending on treatment received.

This policy becomes part of your medical record once signed. The doctor may update this policy as needed; we will notify current patients of any major changes.

I have read and understand the above financial/appointment policy. All of my questions have been answered to my satisfaction and I agree to abide by this policy of Smiles by German Design.

Patient printed name: _____ Date: _____

Patient Signature: _____Date: _____

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ACKNOWLEDGMENT OF PRIVACY PRACTICE

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in my treatment directly or indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such **Notice of Privacy Practices**. I understand that my dental provider has the right to change the **Notice of Privacy Practices** and that I may contact this office 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 privacy information is used and disclosed to carry out any treatment, financial arrangements, or health care operations; and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgment:

_____

_____

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