Mark A. Penshorn DDS, PA
Excellence in Family and Restorative Dentistry

PATIENT INFORMATION

Patient Name: _____ Date: _____
Date of Birth: _____

Gender: M or F Married: _____ Single: _____ Child: _____ Other: _____
Address: _____ City: _____ State: _____ Zip: _____
Phone #: Hm: _____ Wk: _____ Cell: _____
Email: _____
Place of employment: _____ Occupation: _____
How did you hear about our practice? _____
EMERGENCY CONTACT:_____ Phone:_____

RESPONSIBLE PARTY INFORMATION

(write "**self-see above"** if you are the responsible party)

Name: _____Relationship to Patient: _____
Date of Birth: _____ Address: _____
Phone #: Hm_____ Wk: _____ Cell: _____
Place of Employment: _____ Occupation: _____

PRIMARY DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Date of Birth: _____ Social Security #:_____
Subscriber's Address: _____
Subscriber's Phone #: Hm: _____ Wk: _____Cell:_____
Subscriber's Employer: _____Occupation:_____
Subscriber's Insurance ID #:_____
Insurance Company's Name: _____Group #:_____
Insurance Company's Ph #:_____Electronic Payer ID#:_____
Insurance Company's Address: _____

SECONDARY DENTAL INSURANCE INFORMATION

Subscriber's Name: _____ Relationship to Patient: _____
Subscriber's Date of Birth: _____ Social Security #:_____
Subscriber's Address: _____
Subscriber's Phone #: Hm: _____ Wk: _____Cell:_____
Subscriber's Employer: _____Occupation:_____
Subscriber's Insurance ID #:_____
Insurance Company's Name:_____Group #:_____
Insurance Company's Ph #:_____Electronic Payer ID#:_____
Insurance Company's Address:_____

Mark. A. Penshorn, D.D.S., P.A.
2501 FM 3009 Schertz TX 78154
Phone (210) 659-1379 Fax (210) 659-6215

Patient Medical/Dental History

Patient Name: _____Date of Birth: _____

(Please circle any of the following that pertain to your past or present health.)

AIDS or HIV	Epilepsy	Nervous Disorders
Allergies:	Excessive Bleeding	Pacemaker
Hay Fever	Fainting	Psychiatric Care
Latex	Glaucoma	Radiation treatment
Seasonal	Growths	Recent Weight Loss
Other: _____	Headaches	Respiratory Problems
Anemia	Head Injuries	Rheumatic Fever
Arthritis	Heart Disease	Rheumatism
Artificial Heart Valves	Heart Murmurs	Sinus Problems
Artificial Joints	Hemophilia	Special Diet
Asthma	Hepatitis	Stomach Problems
Back Problems	High Blood Pressure	Stroke
Cancer: _____	Low Blood Pressure	Swollen Neck Gland
Circulatory Problems	Jaundice	Tuberculosis
Chronic Diarrhea	Kidney Disease	Tumors
Diabetes	Liver Disease	Ulcers
Dizziness	Mental Illness	Venereal Disease

Do you have any drug allergies or have you had adverse reactions to any medication? _____if yes, tell us the name of the drug: _____the reaction: _____
_____and the date it occurred: _____.

Are you taking any medications at this time? Please list them: _____
_____.

Are you under the care of a physician? _____For what condition? _____.
Physician's name: _____Phone Number: _____.

Have you been admitted to a hospital or needed emergency care in the past 2 years? _____.
Please explain: _____.

Do you have any other health issues that we need to be aware of? _____
_____.

WOMEN:
Do you have reason to believe you are pregnant? _____Due date: _____Are you nursing? _____.

Have you ever taken postmenopausal oral bisphosphonate drugs such as: Actonel, Boniva, or Fosamax?
Please circle: YES or NO. If yes, which medication are you taking? _____.

(Updated 1/13/2021)

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Patient Medical/Dental History Continued

Patient Name:_____ Date of Birth: _____

When was your last dental visit? Date: _____ Where: _____.

What is your primary reason for this visit? _____.

Have you ever had any problems with previous dental care? _____If yes, please explain: _____.

How often do you brush your teeth? _____How often do you floss your teeth? _____.

What type of toothbrush do you use? Soft ____ Medium ____ Hard ____Battery operated ____ Other____.

Do your gums ever bleed when brushing? ____If yes, where? _____.

Do your gums ever bleed when flossing? ____If yes, where? _____.

Do you have any pain in your mouth when brushing? _____If yes, where? _____.

Do you have any pain in your mouth when flossing? _____ if yes, where? _____.

Do you avoid brushing any part of your mouth because of pain? _____.

Do you experience any twinges of pain when you teeth come into contact with:
Hot liquids/food _____Cold liquids/food_____ Sweets _____Sours_____

Do you chew on only one side of your mouth? _____if yes, please explain_____.

Do your gums feel tender or swollen? _____.

Are you aware of clenching or grinding?_____ Day? _____Night?_____.

Do your jaws feel tired? _____Do you snore? _____ Do you gag easily? _____.

Do you wear dentures? _____Do you wear partial dentures? _____.

Do you usually have many cavities? _____Have you ever lost or broken a filling?_____.

Are you familiar with the term "Preventative Dentistry"? _____.

Are you happy with your smile? _____.

What would you like us to accomplish for you? _____
_____.

The above medical and dental history is accurate and complete to the best of my knowledge.

Signature of patient/guardian_____ Date: _____

Mark A. Penshorn, DDS, PA
2501 FM 3009, Schertz, TX 78154
Phone 210/659-1379 Fax 210/659-6215

Authorization for Treatment

I hereby authorize Mark A. Penshorn, D.D.S., to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient named below. I consent to receive care from the staff members he employs, in whatever capacity he deems appropriate within the guidelines of the Texas Board of Dental Examiners. I understand that previous to treatment, full explanation of the procedure/s involved will be given by Dr. Penshorn and /or his staff.

Assignment of Insurance Benefits

In consideration of services rendered, I hereby transfer to Mark A. Penshorn D.D.S. P.A., all rights, title and interest in any payment due to me for services as provided in the policy or policies of insurance held by me. I authorize Mark A. Penshorn, D.D.S., P.A., to release any information requested by my insurance companies to them or their representatives.

Agreement to Pay for Services Rendered

I agree to pay for all services rendered by Mark A. Penshorn, D.D.S., P.A. I understand that I am legally responsible for all costs of treatment, regardless of any estimated insurance balances.

I understand that if Dr. Penshorn does not receive payment from my insurance company/companies within 60 days of treatment, that I will be billed by Dr. Penshorn and that it will become my responsibility to pay the unpaid balance within 30 days and to contact my insurance company to reimburse me.

Understanding of Broken Appointment Policy

I understand that Dr. Penshorn has reserved my appointment time for me and that I need to give at least 24-hour notice to change my appointment. If I do not give this notice, barring emergency situations, he may charge me $25 or more (up to the cost of the procedure I am cancelling) for appointments that I break without giving his office this 24-hour notice, and I agree to pay that broken appointment fee.

Name of Patient: _____

Authorized Signature: _____

Date: _____

(Updated 1/13/2021)

Authorization for Use or Disclosure of Health Information

I, _____, hereby authorize **Mark A. Penshorn, D.D.S. P.A,** to either use or disclose pertinent information regarding my dental care to other dental practitioners, dental labs, my insurance company and its representatives and/or to any other entity that requires such information to assist me in receiving quality dental care. This disclosure includes radiographs and/or photographs, as well as written information.

This authorization shall be in force and effect until I revoke it in writing, at any time I choose, by sending such revocation to

Mark A. Penshorn, D.D.S, P.A.
Attn. Catherine Heath
2501 FM 3009
Schertz, TX 78154

I understand that

- A revocation does not affect health information already sent out under my authorization.
- My treatment, payment, enrollment or benefits will not be based on whether I provide authorization for the requested use or disclosure.
- There is a potential for my protected health information to be re-disclosed by the recipient.
- X-rays are sometimes sent and received via email, which is less secure than fax or postal mail. I would like my information to NOT be sent via email. _____(initial)

_____
Signature of patient or personal representative

_____
Printed name of patient or personal representative

_____
Personal representative's authority

_____
Date

(Updated 1/13/2021)

Acknowledgement of Privacy Practices of Mark A. Penshorn, D.D.S., P. A.

I, _____, have received a copy of the privacy practices of Mark A. Penshorn, D.D.S., P.A.

I authorize the staff members of Mark A. Penshorn, D.D.S., P.A. to call me about appointment reminders, cancellations and other business associated with my dental care. They may leave voice messages about these business matters at my (check all that apply):
_____ home
_____ place of employment
_____ cell/mobile number

I understand that my dental record is the physical and legal property of Mark A. Penshorn, D.D.S., P.A. but that the information belongs to me. I may inspect or obtain a copy of my dental record information by notifying Mark A. Penshorn, D.D.S., P.A. with such a request.

I also authorize Mark A. Penshorn, D.D.S., upon his best judgment, to disclose to my family member, relative or close personal friend, or other persons I identify, any information regarding my general health and/or dental health relevant to that person's involvement in my care.

Signature of Patient_____ Date_____

Staff will fill out this section if patient's signature is not obtained.

Our offices made a good faith effort to obtain acknowledgement of receipt of our notice of privacy practices, but it could not be obtained for the following reasons:

_____ Patient refused to sign

_____ Emergency situation kept us from obtaining patient's signature

_____ Language barriers kept us from obtaining patient's signature.

_____ Other _____