

- O V E R -

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

ADDITIONAL INSURANCE

How much is your deductible? \_\_\_\_\_ How much have you used? \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Union or Local # \_\_\_\_\_  
 Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_ Date Employed \_\_\_\_\_  
 Name of Insured \_\_\_\_\_ Relation to Patient \_\_\_\_\_

INSURANCE INFORMATION

Currently a patient in our office?  Yes  No  E-mail \_\_\_\_\_  
 Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Driver's License # \_\_\_\_\_ Bank \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Name of Person \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
 Responsible for this Account \_\_\_\_\_

RESPONSIBLE PARTY

Person to contact in case of emergency \_\_\_\_\_ Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_  
 Spouse or Parent's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 Employer/School Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Employer/School \_\_\_\_\_ Employer/School Phone ( \_\_\_\_\_ ) \_\_\_\_\_  
 E-mail \_\_\_\_\_ Cell Phone #1 ( \_\_\_\_\_ ) \_\_\_\_\_ Cell Phone #2 ( \_\_\_\_\_ ) \_\_\_\_\_  
 Sex  M  F  Married  Widowed  Single  Minor  Partnered for \_\_\_\_\_ years  Divorced  Separated  
 Name \_\_\_\_\_ Birthdate \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Address \_\_\_\_\_ Home Phone ( \_\_\_\_\_ ) \_\_\_\_\_

PATIENT INFORMATION

Date \_\_\_\_\_  
 SS # \_\_\_\_\_  
 Patient # \_\_\_\_\_

*Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.*



Jimmy F. Pinner, D.D.S.  
 2400 NW Fwy Suite 2400  
 Houston, Tx 77065

## DENTAL HISTORY

Reason for today's visit \_\_\_\_\_  
 Former Dentist \_\_\_\_\_  
 Address \_\_\_\_\_  
 Date of last dental care \_\_\_\_\_  
 Date of last dental X-rays \_\_\_\_\_

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

- Bad breath
- Bleeding gums
- Clicking or popping jaw
- Food collection between the teeth
- Grinding teeth
- Loose teeth or broken fillings
- Sensitivity to hot
- Sensitivity to sweets
- Sensitivity when biting
- Sensitivity to cold
- Sores or growths in your mouth

How often do you brush? \_\_\_\_\_  
 How often do you floss? \_\_\_\_\_

## MEDICAL HISTORY

Physician's Name \_\_\_\_\_

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

Have you ever taken any of the group of drugs collectively referred to as "ten-phen"? These include combinations of Isoniazid, Rifampin, Ethambutol, Pyrazinamide, and Prothionamide. Yes  No

Have you had any serious illnesses or operations? Yes  No

If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion? Yes  No

If yes, give approximate dates \_\_\_\_\_

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

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

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

List medications you are currently taking and the correlating diagnosis:

Allergies:

## AUTHORIZATION AND RELEASE

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 \_\_\_\_\_ and assign directly to \_\_\_\_\_ 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 dentist 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 the 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 \_\_\_\_\_

Payment is due in full at time of treatment unless prior arrangements have been approved.



## JIMMY F. PINNER, D.D.S.

Family & Cosmetic Dentistry

19708 NW Freeway, Suite 2400  
Houston, Tx 77065  
281-517-0442

**Welcome to our office!** We want you to feel comfortable when it comes to paying for the treatment you receive here and we want to feel comfortable asking you for the payment for the treatment we have done for you.

If you have dental insurance, we will accept assignment from your insurance company in most cases. Every company has a different insurance policy with different coverage. Ultimately, it is up to you to know what your policy is and what type of coverage you have. We do our best to make sure we have the most up-to-date information on your insurance, but it is impossible for us to keep up with everyone. We can only estimate what your insurance will cover with the information you provide. You are responsible for any difference between what our fees are and what your insurance company actually covers. If your insurance company says they pay 100% of a procedure, it is 100% of their fees, not our fees. We have no way of knowing what their fees are, so that is why we “estimate” what they will pay. Any balance after the insurance has paid us, you will be billed for and responsible for. You are responsible for any deductible, co-payment, or denied charges from your insurance company the day you come in for treatment. Please be prepared to pay your part each time you have treatment done.

If you do not have dental insurance, payment is due the day you receive treatment. For your convenience, we accept Visa, MC, AE, and Discover, checks or cash. We also have an in-office financing plan available through Care Credit. This is a low monthly payment plan with no interest and no down payment. Please ask us about it!

We are proud of the excellent care and treatment you will receive here. As expensive as modern dentistry is, we strive to keep our fees reasonable for the type of treatment you receive in our office. We value you as a patient and if you have any questions concerning this matter, please ask us. We want to keep our lines of communication open with you.

Thank you,  
**Dr. Pinner**

**I have read the above statement and understand it fully.**

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**Signed Patient/Responsible Party**

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**Date**