

Welcome to Stony Creek Dentistry!

To help us better serve you, please fill out this form completely. If you have any questions or need assistance, please ask us and we will help.

Patient Information:

Name: _____ Date: _____

Male Female Married Single Child

Spouse's Name: _____

SS#: _____ Birth Date _____

Home Phone: _____

Address: _____

Cell Phone: _____

Email: _____

Contact Person (who does not live with you) Name: _____ Phone Number: _____

Responsible Party: if child or another adult

Name of Person Responsible for Account: _____

Relationship to Patient: _____

SS#: _____ Birth Date _____

Home Phone: _____

Address: _____

Cell Phone: _____

Email: _____

Insurance Information: please provide us with your dental insurance card so we may make a copy

Name of Primary Insured: _____

Relationship to Patient: _____

SS#: _____ Insured Birth Date _____

Home Phone: _____

Employer: _____

Work Phone: _____

Employer Address: _____

Insurance Company: _____ Group # _____

Policy #: _____

Insurance Company's Phone Number: _____

Do you have secondary Insurance? _____

Have you used your Insurance this year or paid your deductible? _____

Referral Information:

How did you hear about us? Internet Mail Yellow Pages Drive By Insurance Company Radio Referral

Who referred you to our dental practice? Patient Doctor/Dentist Spouse Friend Family Member

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

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected Health Information. Please see our HIPPA Notice of Privacy Practices. Thank you for choosing our practice to serve your dental needs now and in the future.

Please complete and sign the other side of this form >>

Patient Medical History:

Name of Physician: _____ Last Exam: _____ Office Phone: _____

- | | | | | | |
|--------------------------------------------------|--------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| | Yes | No | | Yes | No |
| 1. Are you under Medical Treatment now? | <input type="checkbox"/> | <input type="checkbox"/> | 4. Do you smoke or use tobacco products? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you taking any Medications? | <input type="checkbox"/> | <input type="checkbox"/> | 5. Do you use controlled substances? | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, what medication(s) are you taking? _____ | | | 6. Have you been Hospitalized for any surgical operation or serious illness within the last 5 years? <input type="checkbox"/> <input type="checkbox"/> | | |
| _____ | | | If yes, please explain _____ | | |
| _____ | | | | | |

3. Do you have or have you had any of the following?

- | | | | |
|---------------------------------------------------------|----------------------------------------------------|-------------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Allergies: | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Latex | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Sulfa | <input type="checkbox"/> Fainting/Dizziness | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Skin Rash/Hives |
| <input type="checkbox"/> Iodine | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Metals | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Nursing | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Aids/HIV | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> TMJ and/or Jaw Pain |
| <input type="checkbox"/> Anemia/Hemophilia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Thyroid Problem |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Due Date _____ | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints/Parts | <input type="checkbox"/> Joint Replacements | <input type="checkbox"/> Pre-Medication | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Blood Disease | | | |
| <input type="checkbox"/> Cancer/Tumor | | | |

Patient Dental History:

Name of Previous Dentist _____ Date of Last Exam or Cleaning _____

1. Have you ever had any complications during/following dental treatment? Yes No
2. Are your teeth sensitive to hot, cold or sweet liquids/foods? Yes No
3. Do you have pain in your teeth or a certain tooth? Yes No
4. Have you ever had clicking or pain in your jaws or difficulty opening or closing? Yes No
5. Do you have frequent headaches? Yes No
6. Do you clench or grind your teeth? Yes No
7. Have you ever had a difficult extraction(s) or prolonged bleeding following an extraction in the past? Yes No
8. Have you had any orthodontic treatment (braces)? Yes No
9. Do you like your smile? Yes No
10. If you could change one thing about your smile or teeth, what would it be? _____

Authorization and Release:

I certify that I have read, answered and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I also authorize the dentist(s) and/or dental office to release any information to third party payors and/or other healthcare practitioners.

X _____

1. **Patient Information:** A fully completed, current patient information registration will be on file in your chart and in our computer during all times the patient is considered active in our practice. Patients are required to inform this office of any changes in their Medical or Dental Health since their last visit and to keep us up-to-date on an annual basis.
2. **Treatment Cost** - Nobody likes to be surprised when it comes to costs. Our policy is to inform you of what your investment will be prior to any treatment. We will review with you our recommended treatment plan and its cost. To make getting a beautiful new smile as easy as possible, we offer several convenient payment methods. Our staff is available to discuss financial arrangements and help you select the method of payment that best meets your needs.
3. **Insurance Benefits:** Please note that your dental insurance policy is a contract between you and your insurance company. We will be happy to assist you in completing and submitting copies of your insurance paperwork to your provider. At your first visit, please bring your insurance card so we may enter the appropriate information into your computerized patient file. We request that you also keep us updated as to any changes in your insurance coverage. Our staff members will be happy to assist you with any questions you may have about insurance, but the ultimate financial responsibility for dental services will be that of the patient, not the insurance company.
4. **Secondary Insurance:** We will accept Secondary dental insurance, but secondary insurance is often difficult to work with. As a courtesy, we will file secondary dental insurance for patients upon submission of proof of secondary insurance. However, if payment is not received in our office within 60 days of the service, the responsibility will be transferred to the patient, and the total outstanding balance will be due from the patient at that time.
5. **Patient Financial Responsibility:** It is the sole responsibility of the patient to insure that our practice accepts their insurance or is in their network. If we are not a provider, then payment in full will be expected at the time of service. All dental insurance co-payments, deductibles, non covered services and amounts above usual and customary as determined by your insurance company are due at the time of service.
6. **Finance Charges:** Any amount your insurance does not cover (deductibles, co-payments, or amounts above usual and customary as determined by your insurance company) will be due at the time of your service. We offer several convenient payment methods, but do not send monthly statements or accept monthly in-office payment plans. There will be a 1.5% finance charge per month on any balance due over 30 days.
7. **Methods of Payment:** Acceptable methods of payment are cash, check, MasterCard or Visa. Additionally, we offer several no interest payment and financing plans through outside financing companies like CareCredit.
8. **On-time Appointments:** We work hard to keep on-schedule and our patients rarely have to wait for their appointment or to see the doctor. We understand that our patients have busy lives and dental appointments are just a small part, but in order to help us keep our schedule it is very important for you to be on time for your appointment.
9. **Missed Appointment:** We understand that emergencies do arise, but if you must cancel your dental appointment we need at least 24 hours notice. Appointments missed and not previously cancelled will be charged a \$25 "no show" fee for routine visits. After two "no show" appointments you may be dismissed from the practice.
10. **Dental Emergencies:** If you have a dental emergency during non-business hours you may leave a message on the answering machine. There will be an emergency number on our answering machine that you may call to reach one of the doctors. Please understand that you may need to leave a message on the doctor's private number with your name and phone number.
11. **Estimates of Charges:** If you are recommended to return for dental treatment we will provide you with a treatment plan and an estimate of what your insurance may or may not cover. Due to the nature of dental care and unforeseen problems that arise during treatment, this is only an estimate and the treatment and fees may change. In the event that your insurance pay less than the amount estimated, you are responsible for the unpaid balance.
12. **Delinquent Accounts:** Accounts that become past due over 90 days are considered delinquent and will be automatically turned over to a collection agency or our attorney. This may result in court action, adverse credit rating reporting and additional penalties and fees. In the event an account becomes delinquent, the undersigned understands that future treatment may be delayed and that the patient or responsible party will be responsible for attorney fees, collection agency fees, cost of collections, court cost and/or other expenses and fees necessary to collect the unpaid balance.
13. **Contacting Patients and Release of Information:** The undersigned grants Family Dental P.C. , Stony Creek Dentistry, its doctors, staff and its assignees the right to telephone them or their contact person at home or work to discuss any matters related to this form. In order to submit claims to your dental insurance or other healthcare providers, we must have your authorization to release these medical/dental records and information. Your signature below authorizes the release of this information.
14. **Health Insurance Portability and Accountability Act (HIPAA), Public Law 104-191:** We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties and your rights. This information, in detail, is available at the front desk and is posted in our waiting room. Please take time to read and understand your rights under HIPAA. If you would like an additional copy of our HIPAA form please ask us and we will make one available to you.

I have read and understand the above information and practice polices for Family Dental P.C. and Stony Creek Dentistry.

Print Name: _____ Patient Signature: _____ Date: _____