WELCOME

We are pleased to welcome you and/or your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____ Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (_____) _____

Spouse's Name _____

Birthdate _____ SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

Is patient covered by secondary insurance? ☐ Yes ☐ No

Subscriber's Name _____

Relationship to Patient _____

Birthdate _____ SS# _____

Insurance Co. _____

Group # _____ Phone (_____) _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext_____ Alt. (_____) _____

Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home (_____) _____ Work (_____) _____ Ext_____ Alt. Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

How often do you floss? _____

How often do you brush? _____

Do you wear contact lenses? ☐ Yes ☐ No

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No	Jaw pain or tiredness	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No	Lip or cheek biting	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No	Loose teeth or broken fillings	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No	Mouth breathing	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No	Mouth pain	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No	Orthodontic treatment	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No	Pain around ear	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No	Periodontal treatment	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No	Sensitivity to cold	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No	Sensitivity to heat	☐ Yes	☐ No
Foreign objects in mouth	☐ Yes	☐ No	Sensitivity to sweets	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No	Sensitivity when biting	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No	Sores or growths in mouth	☐ Yes	☐ No

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Phone (_____) _____ Pharmacy _____ Phone (_____) _____

Please check (☑) "yes" or "no" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No		
Chemical Dependency	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	**Have you ever had or been diagnosed with:**	
Chemotherapy	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Artificial Heart Valves	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Artificial Joints, Screws, Pins, etc.	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No	Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No	Blood Disease	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No	Congenital Heart Lesions	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Hernia Repair	☐ Yes ☐ No
Fainting or dizziness	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Glaucoma	☐ Yes ☐ No	Special Diet/Weight Loss	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Stroke	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Heart Problems	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No		
Hepatitis Type _____	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No	**Are you allergic to:**	
Herpes	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Aspirin	☐ Yes ☐ No
				Barbiturates	☐ Yes ☐ No
Have you ever had any complications following dental treatment?	☐ Yes ☐ No	**Have you ever taken any of these medications?**		Codeine	☐ Yes ☐ No
		Blood Thinners	☐ Yes ☐ No	Ibuprofen	☐ Yes ☐ No
If yes, please describe _____		Coumadin	☐ Yes ☐ No	Latex	☐ Yes ☐ No
		Warfarin	☐ Yes ☐ No	Local Anesthesia	☐ Yes ☐ No
Have you ever been hospitalized or do you have any other health concerns?	☐ Yes ☐ No	Diet Medications	☐ Yes ☐ No	Metals (i.e. gold)	☐ Yes ☐ No
		Dexfenfluramine	☐ Yes ☐ No	Penicillin	☐ Yes ☐ No
If yes, please describe _____		Fen-phen	☐ Yes ☐ No		
		Pondimin	☐ Yes ☐ No	Other _____	
Women: Are you pregnant?	☐ Yes ☐ No	Redux	☐ Yes ☐ No	**Please PRINT all medications now taking:** ____	
Due date _____		Levoxyl	☐ Yes ☐ No		
Are you nursing?	☐ Yes ☐ No	Synthroid	☐ Yes ☐ No		
Taking birth control pills?	☐ Yes ☐ No	**Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva.** ☐ Yes ☐ No			

SIGNATURES

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.

Insurance Assignment: I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company(ies)) and assign directly to Dr. _____ 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 doctor 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 my current treatment plan is completed or one year from the date signed below.

Authorization to Release Protected Health Information: I understand that there may be a need to consult with other health care providers. I voluntarily authorize Dr. _____ (Name of Doctor Disclosing PHI) to use and/or disclose my Protected Health Information (PHI) related to _____ (Describe in detail the Protected Health Information you are authorizing to be used and/or disclosed.). The information will be used and/or disclosed for the purpose of _____ (Describe each purpose for which you are authorizing your Protected Health Information to be used and/or disclosed.). I authorize Dr. _____ (Name of Doctor Receiving PHI) to receive and use the information.

This authorization will end when my current treatment plan is completed or one year from the date signed below. I understand that once the information is released it may be re-disclosed by the recipient and may no longer be protected by federal privacy regulations. I understand that I may revoke this authorization at any time by notifying, in writing, the above-named doctor disclosing the PHI. However, if I do revoke this authorization, it will not have any effect on any actions taken by the above-named doctor disclosing the PHI prior to their receipt of the revocation. I understand that my treatment cannot be conditioned on whether I sign this authorization. I understand I may refuse to sign this authorization.

_____ Please print name of Patient, Parent, Guardian or Personal Representative

_____ Relationship to Patient

_____ Date

DOCTOR'S COMMENTS & UPDATE

(to be completed by the dentist)

Medical Clearance Letter Sent to _____ Date _____

Results _____

Signature _____ Date _____

OUR FINANCIAL POLICY

Thank you for choosing Stines Dental Associates as your dental care provider. We are committed to providing you with the best care. If you have dental insurance, we would like to help you receive your maximum benefits. In order to achieve this goal, we need your assistance, and your understanding of our financial policy. Please understand that payment of your bill is considered a part of your treatment. We require that you read and sign the following prior to any treatment.

All patients must complete our Patient Registration and Health History forms before seeing the doctor.

FULL PAYMENT IS DUE TIME OF SERVICE. WE ACCEPT CASH, CHECK, OR VISA/MASTER CARD/ DISCOVER.

Regarding Insurance

If you provide us with complete insurance information, we will be happy to process your insurance claim for you. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. In the event that we do accept assignment of benefits, we require that you pay your co-payment and deductibles at time of any and all services.

Due to many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. It is your responsibility to know your individual coverage. Failing to comply with this suggestion could result in you, the patient, being responsible for all costs incurred including finance charges (4% a year) on balances over 90 days. Please remember your insurance policy is between you and your company and not with the insurance company and your doctor.

We will gladly discuss the cost of your proposed treatment and answer any questions that you may have. Please realize that not all services are a covered benefit in all contracts. We must emphasize that as a dental care provider, our relationship is with you, not your insurance company, while filing of insurance claims is a courtesy we extend to all our patients.

Usual & Customary Rates

Our practice is committed to provide the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed appointments

Unless canceled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of $50.00 per missed visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

X_____Date

Signature of patient of parent (if a minor)

Stines Dental Associates, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).