STUART FAMILY DENTAL P.C.

Name: _____ _____ _____ DOB: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip Code: _____

Best number to reach you: _____ Best method of contact? Calling Texting

Employer: _____ SS#: (needed for most insurances)_____

Marital Status: Single/ Married/ Divorced /Widowed **Referred By**: _____

Emergency Contact: _____ Phone: _____

If you are completing this form for another person, your name and your relationship to them is?

_____

DENTAL INSURANCE

Primary Company_____ Group No. _____
I.D. Number from Insurance card or SS# (Required) _____
Insurance Address_____
Insurance Phone # _____
Subscriber _____
Relationship to patient _____ Date of Birth ____/____/_____
Subscriber's Employer _____

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your needs. Your answers are for our records only and will be considered confidential.

Are you currently having any discomfort? _____ Where? _____

Date of last dental visit? _____

Have you ever been treated for periodontal disease (gum disease, pyorrhea, trench mouth)? **Yes**◯ **No**◯

_____

Do you have, or have you ever had any of the following:

Bleeding, sore gums?	**Yes**◯	**No**◯	Shifting in bite?	**Yes**◯	**No**◯
Unpleasant taste/bad breath?	**Yes**◯	**No**◯	Change in bite?	**Yes**◯	**No**◯
Swelling/lumps in mouth?	**Yes**◯	**No**◯	Burning tongue/lips?	**Yes**◯	**No**◯
Orthodontic treatment (braces?)	**Yes**◯	**No**◯	Frequent blister, lips/mouth?	**Yes**◯	**No**◯
Clenching/grinding?	**Yes**◯	**No**◯	Sensitive teeth (hot or cold?)	**Yes**◯	**No**◯
When _____			Sensitive to sweets?	**Yes**◯	**No**◯
Clicking/popping jaw?	**Yes**◯	**No**◯	Sensitive to biting?	**Yes**◯	**No**◯
Difficulty opening or closing jaw?	**Yes**◯	**No**◯	Impacted food?	**Yes**◯	**No**◯
Loose teeth?	**Yes**◯	**No**◯	Biting cheeks/lips?	**Yes**◯	**No** ◯
Removable dental appliances?	**Yes**◯	**No**◯			

_____

Please rank the following options in the order in which they would prevent you from having dental treatment.

(1-4, 4 being the highest) Fear of pain _____ Lack of concern _____ Cost of treatment_____ Missing work time _____

Have there been changes in your general health in the past year? **Yes**◯ **No**◯
Physician: _____ Address: _____
Last Physical Exam _____
Have you had any serious illness, operation, or been hospitalized in the past 5 years? **Yes**◯ **No**◯
Please explain:

List any and all medications – prescription or non-prescription - that you are currently taking: (we will gladly take a copy of your medication list if you have numerous medications)

Are you on Aspirin Therapy? **Yes**◯ **No**◯ Are you on blood thinners? **Yes**◯ **No**◯ **If** so, which one(s)?
_____
Have you taken or are you taking Bisphosphonates (Fosamax, Actonel, Boniva, Didronel)? **Yes**◯ **No**◯
Please list which one & how long you've been taking: _____
Do you use tobacco? **Yes**◯ **No**◯
If yes, what form? _____ How much per day? _____ How long have you used it? _____
_____

Do you have or had any of the following diseases or problems: (Circle all that apply)

AIDS/HIV Positive	Epilepsy/Seizures	Parathyroid Disease
Alzheimer's	Excessive Bleeding	Radiation Treatments
Anaphylaxis	Fainting/Dizziness	Renal Dialysis
Anemia	Frequent Cough	Rheumatic Fever
Angina	Frequent Diarrhea	Rheumatism
Arthritis/Gout	Frequent Headaches	Scarlet Fever
Artificial Heart Valve-Date: _____	Genital Herpes	Shingles
Artificial Joint- Date: _____	Glaucoma	Sickle Cell Disease
Asthma	Heart Attack/Failure- Date: _____	Sleep Apnea
Blood Disease	Heart Murmur	Spina Bifida
Blood Transfusion	Heart Pacemaker- Date: _____	Stomach/Intestinal Disease
Bruise Easily	Hepatitis A	Stroke
Cancer	Hepatitis B or C	Swelling of Limbs
Chemotherapy	High/Low Blood Pressure	Thyroid Disease
Chest Pains	High Cholesterol	Tonsillitis
Cold Sores	Hypoglycemia	Tuberculosis
Congenital Heart Disorder	Irregular Heartbeat	Tumors/Growths
Cortisone Medicine	Kidney Problems	Ulcers
Diabetes	Liver Disease	
Drug Addiction	Mitral Valve Prolapse	
Emphysema	Osteoporosis	

If you circled Diabetes, what type? _____ Is it controlled? _____ Your Regular Blood Sugar Level: _____
Last A1C:_____Date: _____
Do you have any disease, conditions, or problems not listed you think we should know about?
Explain:

Are you allergic to or have you had a reaction to any of the following?

Aspirin	Penicillin	Sulfa Drugs	Codeine
Latex	NSAIDS	Local Anesthetics	Metal

Other medical allergies:
Women: Are you pregnant? **Yes**◯ **No**◯ Are you nursing? **Yes**◯ **No**◯ Are you taking birth control pills? **Yes**◯ **No**◯

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Signature:_____ **Date:**_____

Acknowledgment of Receipt of Notice of Privacy Practices

****You may refuse to sign this acknowledgment****

I have received or read a copy of this office's Notice of Privacy Practices.

_____

(Printed Name)

_____

(Signature)

_____

(Date)

For Office Use Only

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

- Individual refused to sign
- Communication barrier prohibited acknowledgment
- Emergency prevented acknowledgment
- Other (Please specify)

The HIPPA privacy law requires that we are only authorized to communicate with the patients themselves, a guardian, insurance providers, dental offices providing continuity of care, or primary care physicians, unless we have authorization in writing by the patient to communicate with others on their behalf. Please provide all family members or friends you want us to be able to speak with. **Spouses are not automatically included; their names MUST be explicitly stated below.** You may opt out by checking the "Do Not Release Information" box below.

****

Authorization to speak with family/friend (including spouse)

I give the following named person(s) authorization to take messages or to speak with the office of Ames Cross, DDS (Stuart Family Dental, PC), on my behalf regarding (**please check all items authorized**):

Name of authorized person(s): _____ Relationship: _____

Phone no.: _____

___Appointments ___Financial ___Dental Treatment ___Insurance ___Other (explain) _____

Authorization to leave dental information by alternate means:

I authorize Ames Cross, DDS and staff to use the following telephone number(s) provided on the patient registration form to leave messages on voice mail for reminder calls and other patient matters.

___Home phone ___Work phone ___Cell Phone

___DO NOT RELEASE INFORMATION TO ANYONE

I understand that my express consent is required to release any health care information.

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will remain in effect until revoked by me in writing. It is my responsibility to notify my provider should I change one or more contacts listed above.

Patients Name: _____ D.O.B.: _____

Signature: _____ Date: _____

STUART FAMILY DENTAL P.C.

Sleep and Smile Evaluation

Here at Stuart Family Dental, we are committed to helping you obtain the smile and sleep you have always wanted. Please take a moment to complete this questionnaire. This information helps ensure we are serving you to the best of our ability.

Smile:

- Are you happy with the way your teeth look when you smile?
- Are you happy with the color of your teeth?
- Do you have any spaces between your teeth that you are unhappy with?
- Do you have any old fillings or treatment you are unhappy with?
- Is there anything you would change about your smile? What would that be?

Sleep:

- Do you own and/or wear a CPAP?
- Do you feel well rested after a full nights rest?
- Do you snore?
- Has your partner ever noticed you snoring, choking, or gasping in your sleep?
- Does anyone in your family have sleep apnea?

STUART FAMILY DENTAL P.C.

2019 Financial Agreement

Our goal is to provide the highest quality of dental care possible and to have a clear communication of our financial policy.

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE. If a procedure requires multiple appointments, payment is due in full at the first appointment.

PAYMENT OPTIONS ARE:

- **CASH**
- **CHECK**
- **CREDIT CARD** (Visa, MasterCard, Discover, AmEx, HSA and Flex cards)

PATIENTS WITH INSURANCE: The PATIENT is responsible for their deductible and any ESTIMATED and/or non-covered portion of the procedure at the time of service. If your insurance company does not pay within 60 days, we will bill you directly for the full balance.

18% annual interest rate will be applied to any balance over 90 days old.

A $35 processing fee will be applied to any account for returned checks.

****We understand every situation is unique. Please do not hesitate to ask about in house financing options.**

I, _____, agree to these financial terms.
(printed name)

Signature: _____ Date: _____