New Patient Registration

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to assist you.

Patient Information

Date: ___________________________ Social Security # _______ - _______ - _______

Patient: ______________________ ______________________ ________________________
Last *First* *MI*

Address: ______________________________________ Home Phone: ____________________

______________________________________ Cell Phone: ____________________
City *State* *Zip*

Date of Birth: ____/_____/_____ Gender: ☐ Male ☐ Female Email:________________________

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Dental Insurance Coverage

Is this patient the insured?: ☐ Yes ☐ No Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Name: ____ DOB: ___/___/___
Last *First* *MI*

Insurance Carrier: ____

Insurance Address: ____

Insurance Phone :______________________ Employer: __________________________________

ID/Social #: _____________________________ Group: ______________________________

Responsible Party (if not patient)

Guarantor's Name: ____ DOB: ___/___/___

Relationship to Insured ☐ Spouse ☐ Parent ☐ Other Phone: ____________________

Address: __________________________________City_______________State____Zip______

Employment/School Information

Employer/School____Phone:___________________

Address: ____Occupation:______________

City__________________________________State__________Zip___________

How did you hear about Stone Creek Dental?

○ Location ○ Mailer ○ Insurance ○ Telephone Book Other _________________

Patient name: ______________________________

Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you taking any prescription or over-the counter medications? ○ Yes ○ No

If yes, please list ______________________________

____

Do you take a blood thinner? (such as Aspirin, Coumadin, Plavix) ○ Yes ○ No

Do you have, or have you had, any of the following?

☐ Abnormal Bleeding	☐ Epilepsy/Seizures	☐ Jaw Pain	☐ Shingles
☐ AIDS/HIV	☐ Fainting Spells	☐ Kidney Problems	☐ Shortness of Breath
☐ Anemia	☐ Fever Blisters/Cold Sores	☐ Liver Disease	☐ Sleep Apnea
☐ Arthritis/Rheumatism	☐ Glaucoma	☐ Low Blood Pressure	☐ Sinus Problems
☐ Artificial Heart Valves	☐ Heart Attack/Stroke	☐ Mitral Valve Prolapse	☐ Skin Rash
☐ Artificial Joints	☐ Heart Murmur	☐ Nervous Problems	☐ Substance Abuse
☐ Asthma	☐ Heart Problems	☐ Pacemaker	☐ Swelling of Feet or Ankles
☐ Blood Transfusion	☐ Heart Surgery	☐ Radiation to Head or Neck	☐ Swollen Neck Glands
☐ Cancer/Chemo/Radiation	☐ Hemophilia	If yes, how many rads? ____	☐ Thyroid Problems
☐ Congenital Heart Defect	☐ Hepatitis, Type ____	☐ Respiratory Disease	☐ Tonsillitis
☐ Depression	☐ Herpes ○ I, ○ II	☐ Rheumatic Fever	☐ Tuberculosis
☐ Diabetes, Type____	☐ High Blood Pressure	☐ Scarlet Fever	☐ Ulcers/Colitis
☐ Emotional/Mental Disorders	☐ Jaundice	☐ Severe/Frequent Headaches	☐ Venereal Disease
☐ Emphysema			

Have you had any serious illness not listed above? ○ Yes ○ No ○ N/A ______________________________

WOMEN ONLY

Are you pregnant or *is there a chance you may be pregnant*? ○ Yes ○ No

due date ______________

Are you nursing? ○ Yes ○ No

Are you taking oral contraceptives? ○ Yes ○ No

Allergies: Are you allergic or sensitive to any of the following?

☐ Latex ☐ Erythromycin ☐ Codeine ☐ Sulfa ☐ Penicillin ☐ Aspirin ☐ Epinephrine ☐ Lactose ☐ Other ____________

Patient name: ______________________________

History, continued

Other family members seen by us? ______________________________ Current/Previous Dentist______________

Would you like us to request your records from your previous dentist? ○ Yes ○ No

What qualities do you look for in choosing a dentist? ______________________________

Why did you leave your last dentist? ______________________________

If you could change anything about your smile, what would it be? ______________________________

Describe your current health ______________________________

Are you currently in pain? ○ Yes ○ No If yes, describe ______________________________

How often do you floss? ____________ Do your gums ever bleed? ○ Yes ○ No Do you ever have jaw joint pain? ○ Yes ○ No

Are you under a physicians care? ○ Yes ○ No *If yes, name of physician:* ______________________________

Have you ever been hospitalized or had major surgery? ○ Yes ○ No *If yes, please explain:* ______________________________

Are you in pain? ○ Yes ○ No ______________________________

Do you have problems laying back? ○ Yes ○ No ______________________________

Have you ever had a bad experience in a dental office? ○ Yes ○ No ______________________________

Are you nervous about dental treatment? ○ Yes ○ No ______________________________

Do you use, or have you used, Phen-Fen or Redux? ○ Yes ○ No ______________________________

Are you on a special diet? ○ Yes ○ No ______________________________

Do you use/have used tobacco? ○ Yes ○ No ______________________________

Do you use/have used controlled substances? ○ Yes ○ No ______________________________

SIGN HERE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

____

SIGNATURE OF PATIENT, PARENT, GUARDIAN DATE

Office Use Only

Date ________, Initials _________, BP ________/________, Pulse _______

ASA Classification: _________

Dr.: ______________________________

Date: ________________

Conditions of Treatment, Payment and Appointments

Patient:_______________________________________D.O.B.:_____________

Appointments

We will do our best to schedule your appointment at a convenient time. **48 hours** is required if you are unable to keep your scheduled appointment. We reserve the right to charge you a **$50 fee** if we do not receive the 48 hour minimum notice requirement. Appointments are confirmed by phone whenever possible. If we are unable to reach you, we trust that you will keep your appointment. If a patient arrives 10 minutes or more late, we reserve the right to reschedule the appointment.

initials __________ date __________

Insurance, participating provider

We are participating providers for certain insurance companies and will bill those insurance companies directly as per our contracts. We will try to answer any questions you may have about your insurance; however, **we must emphasize that as a dental care provider our relationship is with you – not your insurance company**. It is your responsibility to know your insurance policy and be familiar with your coverage. All deductibles and co-payments are due at the time of service. Any amount **approved** by your insurance company, but not paid, will be your responsibility. Contractual adjustments will be taken as per our contract with your insurance company.

initials __________ date __________

Insurance, all other plans

If you have dental insurance we do not contract with, as a courtesy to you, we will bill your insurance company. We will try to answer any questions you may have about your insurance; however, **we must emphasize that as a dental care provider our relationship is with you – not your insurance company**. It is your responsibility to know your insurance policy and be familiar with your coverage. If you have any questions regarding coverage, contact your insurance company. All deductibles and co-payments are due at the time of service. I understand I am responsible for any amount not covered by my insurance company.

initials __________ date __________

Financial

Payment is due at time of service. We accept:

- cash
- checks
- VISA
- MasterCard
- Care Credit

Care Credit is an outsourced credit plan for patients who wish to make monthly payments (upon approval of the creditor); applications are available upon request. Applications must be completed before any dental treatment is started.

A $20 fee will be added to your account for all returned checks. In accordance with the Federal Truth-in-Lending Act, any balance older than 60 days will be subject to a billing charge of $5 per month or a finance charge of 21% APR, whichever is greater. Should your account be placed for collections, you will be responsible for all additional fees.

initials __________ date __________

Consent for Services and Assignment of Benefits

I have read the above and give Stone Creek Dental consent to render dental services. This consent shall extend to all treatments, services, medications and operations upon the teeth and jaws as may be necessary to correct oral deficiency, abnormalities and/or infection. I consent to the administration of anesthetic agents for my dental treatment. The use and purpose of the anesthesia, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantee or assurance is made as to the results that may be obtained. I understand, and consent, that I may be tested for any communicable disease in the event of an occupational blood exposure to a healthcare provider. I authorize Stone Creek Dental to release any information and records concerning my treatment as may be necessary to process insurance claims or payments for the care and treatment provided.

I understand, and agree, that regardless of my insurance, I am responsible for the balance on my account for professional services rendered. I have read and initialed the above information and agree to the policies.

______________________________________ ____________________

Patient (or Guardian) Signature Date

Policy on Composite Restorations

Our practice has chosen to use composite restorations (tooth colored fillings) instead of amalgam restorations (silver fillings) in most cases. Though the price difference is usually minimal, some insurance carriers will not cover composite fillings to their full amount but rather to the amount the carrier would have paid for an amalgam filling. ***The difference in cost between the amalgam and composite restorations is your responsibility.***

Please indicate your preference by **initialing one** of the statements below and signing at the check mark.

___________ I have read and understand the above and accept responsibility for any amounts not covered by my insurance carrier.

OR

___________ I have read and understand the above policy, however, I request that the staff of Stone Creek Dental only use amalgam (silver) restorations in my treatment.

Patient's Name: ____Date of Birth:________
(please print)

Signature: ✓___________________________________Date: ______________________

Relationship to patient: ____self ____spouse ____parent ____other.

Print your name below if you are not the patient.

Name: ____

Notice of Privacy Practice

This notice describes how health information about you may be used and disclosed and how you can get access to this information. ***Please review it carefully***.

Federal and state law requires us to maintain the privacy of your health information. That law requires us to give you this notice about privacy practices, our legal duties and your rights concerning your health information. This notice takes effect April 14, 2003. We reserve the right to make revisions to this policy. Should revisions be made, you will be notified in writing and a copy of the revised policy will be made available at your request. You may request a copy of this notice at any time.

Uses and disclosures of health information: *Please note: we will not disclose any information without your **written** consent*.

Treatment: We may use your health information for treatment or disclose it to another health care provider who will be providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations such as quality assessment and improvement activities, protocol development, training programs and accreditation, certification or licensing activities. We may also disclose your information to detect or prevent health care fraud and abuse.

On Your Authorizations: You may give us written authorization to use your health information or to disclose it to anyone for any purpose.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders such as voice mail messages, postcards or letters.

Public Benefits: We may use or disclose your health information as authorized by law to assist in disaster relief efforts, public health activities, abuse and neglect reporting, workers compensation, Food and Drug administration, church ministries, law enforcement, judicial proceedings and for specialized government functions.

Notice of Privacy Practice Cont.
And Information Release

Patient Rights

Access: You have the right to look at or get copies of your health information.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement except in an emergency.

Alternative Communication: You have the right to request in writing that we communicate with you about your health information by alternative means or to alternative locations.

Amendment: You have the right to request in writing that we amend your health information. Your request must explain why we should amend the information. We may deny your request under certain circumstances.

Upon request, a copy of this Notice of Privacy Practices is available for your records.

Protected Health Information Release: Patients 18 years and older.

- ☐ Only release information to me personally.
- ☐ You have my permission to release information about my dental health to my spouse.

  Spouse's name____________________________ Phone_______________
- ☐ You have my permission to leave information on my answering machine regarding my dental care or test results.
- ☐ You have my permission to email information regarding my dental care or test results to:

  Email Address:____
- ☐ You have my permission to talk with my children or other family members involved with my dental care.

  Name___________________________________Phone_________________
  Name___________________________________Phone_________________
  Name___________________________________Phone_________________
  Name___________________________________Phone_________________
  Name___________________________________Phone_________________
- ☐ Other____

____ _________________________

Patient Signature Date

Privacy Practices Acknowledgement

I have read the Notice of Privacy Practices and I have been provided an opportunity to review the information and ask any questions. I also understand that a copy of the Notice of Privacy Practices will be provided to me, for my records, upon my request.

Patient's Name: ____Date of Birth:________
(please print)

Signature: _____________________________________Date: ______________________

Relationship to patient: ____self ____spouse ____parent ____other. *Print your name below if you are not the patient.*

Name: ____

Copy of Privacy Practices given to patient by ____________initials ___________date