



# 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: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_  
Cell Phone: \_\_\_\_\_  
Date of Birth: <sup>City</sup>\_\_\_\_/\_\_\_\_/\_\_\_\_ <sup>State</sup>\_\_\_\_ <sup>Zip</sup>\_\_\_\_ 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: \_\_\_\_/\_\_\_\_/\_\_\_\_  
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?

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

<input type="checkbox"/> Latex	<input type="checkbox"/> Erythromycin	<input type="checkbox"/> Codeine	<input type="checkbox"/> Sulfa	<input type="checkbox"/> Penicillin	<input type="checkbox"/> Aspirin	<input type="checkbox"/> Epinephrine	<input type="checkbox"/> Lactose	<input type="checkbox"/> Other _____
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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 \_\_\_\_\_

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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.

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\_\_\_\_\_  
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