



Welcome! The benefits of a happy, healthy smile are immeasurable!
 Our goal is to help you reach and maintain maximum oral health.
 Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Name _____

Preferred Name _____ M F

Address _____

City _____ State ____ Zip _____

Home # _____ Work # _____

Cell # _____ Other # _____

Single Married Divorced Widowed Separated

Birthdate ___/___/___ Age ____ SS# _____

Email: _____

Employer: _____

Address: _____

City _____ State ____ Zip _____

Occupation: _____ How long there? _____

Whom may we thank for referring you to our practice?

Other family members seen by us _____

STUDENT STATUS *If applicable*

School _____

School Address _____

City _____ State ____ Zip _____

Grade _____ Full time Part time

SPOUSE INFORMATION *If applicable*

Name _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/___/___

Email: _____

INSURANCE INFORMATION

Primary Insurance Company _____

Address _____

City _____ State ____ Zip _____

Group# _____

Insured's Name _____

Relationship to Insured _____

Insured's Birthdate ___/___/___ Insured's ID# _____

Insured's SS# _____

Insured's Employer _____

Secondary Insurance Company _____

Address _____

City _____ State ____ Zip _____

Group# _____

Insured's Name _____

Relationship to Insured _____

Insured's Birthdate ___/___/___ Insured's ID# _____

Insured's SS# _____

Insured's Employer _____

ACCOUNT INFORMATION

Person Responsible for Account
 Name _____

Relationship to Patient _____

Billing Address _____

City _____ State ____ Zip _____

Home # _____ Work # _____

Cell # _____ Birthdate ___/___/___

SS# _____

COMMUNICATION

In an effort to be environmentally friendly and technologically advanced, we use emails and text messages often for our correspondences (Appointment Reminders, Newsletters, Important Events, etc). Please indicate if you would not like to have either of those:

[] No text messages please.

[] No emails please.



MEDICAL HISTORY

Do you smoke or use tobacco in any form? Y N

Are you taking any prescription, over the counter, or herbal supplement drugs? Y N

Please list with dosage: _____

Have you ever taken Phen-Fen (Redux)? Y N

Do you drink grapefruit juice? Y N

FOR WOMEN ONLY

Are you taking Birth Control Pills? Y N

Are you pregnant? Y N

Could you be pregnant? Y N

Are you trying to get pregnant? Y N

Are you breastfeeding? Y N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?

Y N Abnormal Bleeding

Y N Alcohol/Drug Abuse

Y N Asthma

Y N Cancer/Chemotherapy

Y N Diabetes. If Yes, what was your last HbA1c level? ____

Y N Acute Narrow Angle Glaucoma

Y N Heart Attack. If Yes, when? _____

Y N Hemophilia

Y N Hepatitis. If Yes, what type? _____

Y N Herpes

Y N High Blood Pressure If Yes, normal BP? ____/____

Y N HIV/AIDS

Y N Pacemaker

Y N Psychiatric Problems

Y N Seizures

Y N Stroke

Y N Tuberculosis

Y N Venereal Disease

Any other medical conditions that we should be aware of?

TO DETERMINE WHETHER ANTIBIOTIC PREMEDICATION MAY BE NECESSARY PRIOR TO DENTAL PROCEDURES:

Y N Artificial Joints. When replaced? _____

Y N Artificial Heart Valves

Y N Past incidence of Infective Endocarditis

Y N Serious Congenital Heart Defect (*not* Mitral Valve Prolapse, Septal Defects, Rheumatic Heart Disease)

Y N Heart Transplant

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

Y N Aspirin

Y N Latex

Y N Codeine

Y N Penicillin

Y N Dental Anesthetics

Y N Tetracycline

Y N Erythromycin

Y N Jewelry/Metals

Other Allergies _____

MEDICAL INFORMATION

Do you have a primary care physician? Y N

Physician's Name _____

Phone _____

Date of Last Visit ____/____/____

Are you currently under the care of a physician? Y N

Please explain _____

MEDICAL HISTORY UPDATES

Date	Changes	Pt Initials
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____
____/____/____	_____	_____



DENTAL QUESTIONNAIRE

What brings you into our office today?

Are you having any of the following?

- Y N Tooth pain or sensitivity?
- Y N Headaches, Earaches, Neck Pain?
- Y N Broken Teeth or Fillings?
- Y N Bleeding, swollen, or irritated gums?
- Y N Loose, chipped or shifting teeth?
- Y N Bad breath?
- Y N Clenching or grinding your teeth?

If you could change your smile, would you:

- Make your teeth whiter
- Make your teeth straighter
- Close spaces between your teeth
- Replace silver fillings with tooth-colored restorations
- Repair chipped teeth
- Replace missing teeth
- Replace old crowns that don't match
- Have a Smile Makeover

Would you be interested in having any dental treatment completed while you are Sedated? [] No [] Yes

When was your last dental appointment?

Approximate

Date _____

Reason _____

Previous Dentist: _____

City: _____ State _____

Why did you leave your previous dentist?

What is the most important thing to you about your smile and dental health?

Is there anything we can do to make you more comfortable at our office?

What is the most important thing to you about your dental visit today?

Stonecreek Dental Care ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____, understand that Stonecreek Dental Care abides by the HIPAA Law and will protect the privacy of my personal information. I have been given a copy of this Stonecreek Dental Care's Notice of Privacy Practices.

Please Print Name _____

Signature _____

Date _____

FOR OFFICE USE ONLY

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

- Individual refused to sign
- Communication barriers prohibited us from obtaining acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other _____



STONECREEK DENTAL CARE FINANCIAL POLICY

Thank you for choosing our practice to provide your dental needs. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to treatment.

Payment is due in full at the time of service. Our practice does not accept monthly payments. We accept cash, checks, and all major credit and debit cards. We have financing available from 3 months all the way up to 5 years and have options for those who may not be able to obtain financing.

REGARDING TREATMENT ESTIMATES

- Fees are estimates only, and are valid for 3 months from the time treatment is presented. Treatment can be altered if your dental needs change. You will be notified of any changes. You will always be given a treatment estimate for future appointments.
- We are required by law to inform you of your dental condition. Our goal is to educate patients about the treatment they need and help them achieve optimum oral health. We recommend dental treatment based on necessity not based on what your insurance company may or may not cover. Once we provide you with this information, it is then your decision to accept or deny treatment.

REGARDING INSURANCE

- Our practice collects a standard amount before procedures are performed, this amount DOES NOT reflect what your insurance will pay, but instead what we prefer to collect at the time of service. We may call to verify your insurance, but we do not get detailed policy information such as waiting periods, limitations, or special clauses.
- Please read your dental insurance policy carefully, it is your responsibility to be aware of your plan benefits as well as its limitations.
- Our office is unable to wait past 60 days for insurance claims to be paid. If your claim takes longer than 60 days to be processed, you will be asked to pay that portion and seek reimbursement from your insurance.

OUR COLLECTION PERCENTAGES FOR THOSE WITH INSURANCE ARE AS FOLLOWS:

Preventative Services- 0%

(Routine Cleanings, exams, x-rays, fluoride treatments will be billed to the insurance, any balance remaining after your insurance pays is due in full immediately. ****Full mouth series and panoramic x-rays are often not paid at 100%. These important x-rays are necessary on your first visit and every 3-5 years thereafter.

Basic and Major Services- 50%

We collect 50% plus your deductible at the time of service on all other treatment. In the case that your fees go over your yearly insurance maximum, the amount over the maximum will also be collected.

- Any treatment totaling over \$3000 will be collected in full, and you will be reimbursed when the insurance pays.
- Those with **DELTA DENTAL** will have different copay collection rates, as we are a contracted provider with only that insurance company.
- If your insurance pays more than expected, you will be reimbursed immediately. If a balance remains after insurance pays, you will receive a statement and payment is due in full within 30 days.
- Usual and Customary Rates: Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible to pay the difference between our fee and what your insurance company determines to be "usual and customary" rate.

MINOR PATIENTS

No minor will be seen in our office without a parent or guardian present. The parent accompanying the minor child is responsible for payment. In the case of divorce, regardless of decree, the parent who brings the child and has signed the financial agreements is responsible to pay for the child's services.

MISSED APPOINTMENTS

Unless cancelled 24 hours in advance, our policy is to charge \$25 for missed appointments at our discretion. For lengthy sedation and periodontal treatment appointments there is a non-negotiable \$50 charge.

WE GUARANTEE OUR WORK! YOU WILL RECEIVE A WRITTEN COPY OF OUR WARRANTY WHEN YOU RECEIVE DENTAL TREATMENT.

I understand this financial policy and that I am responsible to pay all fees associated with my treatment at Stonecreek Dental Care. I understand that estimates given to me are ONLY ESTIMATES and I am still responsible for any balance not covered by my insurance company.

Patient Signature _____ Date _____