# WELCOME

## Patient Information

*Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.*

(Please Print)

Name _____ SS#_____ Date _____
First Middle Initial Last

Address_____ City _____ State _____ Zip _____

Sex: ❑ Female ❑ Male Birthdate_____ E-mail _____

Home Phone (____)_____ Cell Phone (____)_____ Work Phone (____)_____

Do you prefer to receive calls at: ❑ Home ❑ Work ❑ Cell ❑ No preference

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced ❑ Minor

Patient Employer/School _____ Occupation _____

Employer/School Address_____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (____)_____

Person to contact in case of emergency _____ Phone (____)_____

Whom may we thank for referring you to us? _____

## Responsible Party

Name of person responsible for this account _____

Relationship to Patient _____ Phone (____)_____

Address_____ City _____ State _____ Zip _____

Name of Employer _____ Work Phone (____)_____

## Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate _____ Social Security # _____ Date employed _____

Name of Employer _____ Work Phone (____)_____

Address_____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ADDITIONAL INSURANCE? ❑ No ❑ Yes IF YES, PLEASE COMPLETE THE FOLLOWING:

Name of Insured_____ Relationship to Patient_____

Birthdate _____ Social Security # _____ Date employed _____

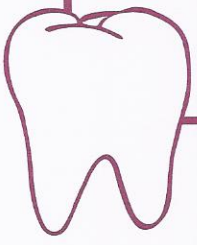
Name of Employer _____ Work Phone (____)_____

Address_____ City _____ State _____ Zip _____

Insurance Co. _____ Group # _____ Employer # _____

Insurance Co. Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____



# Karla M. Stanz, D.M.D.

# Dental History

Name _____ Date of last exam _____

Former Dentist _____ Date of last dental X-rays _____

Reason for today's visit _____

How often do you brush? _____ How often do you floss? _____

Please check any of the following conditions that apply to you:

- ❑ Bad breath
- ❑ Bleeding gums
- ❑ Clicking or popping jaw
- ❑ Food collection between teeth
- ❑ Grinding teeth
- ❑ Loose teeth or broken fillings
- ❑ Periodontal treatment
- ❑ Sensitivity to cold
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Sensitivity when biting
- ❑ Sores or growths in your mouth

# Medical History

Physician _____ Date of last visit _____

Please list all medications you are currently taking: _____

Allergies: _____

(*Women*) Are you pregnant? ❑ Yes ❑ No Nursing? ❑ Yes ❑ No Taking birth control pills? ❑ Yes ❑ No

Check (✓) if you have had any of the following:

- ❑ AIDS
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves*
- ❑ Artificial Joints*
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding Abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemical Dependency
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Congenital Heart Defects*
- ❑ Cortisone Treatments
- ❑ Cough, Persistent
- ❑ Cough up Blood
- ❑ Diabetes
- ❑ Epilepsy
- ❑ Fainting
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur*
- ❑ Heart Problems*
  Describe _____
- ❑ Hemophilia
- ❑ Hepatitis
  Type _____
- ❑ Hernia Repair
- ❑ High Blood Pressure
- ❑ HIV Positive
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse*
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever*
- ❑ Scarlet Fever
- ❑ Shortness of Breath
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Thyroid Problems
- ❑ Tobacco Habit
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Ulcer
- ❑ Venereal Disease

**This condition may require antibiotic premedication.*

❑ Antibiotic premedication required prior to treatment. Please specify: _____

Have you ever taken any of these medications?

**Osteoporosis Medications:** ❑ Fosamax ❑ Other _____

**Diet Medications:** ❑ Dexfenfluramine ❑ Fen-phen ❑ Pondimin ❑ Redux

**Blood Thinners:** ❑ Coumadin ❑ Warfarin

**Other:** ❑ Levoxyl ❑ Synthroid

# Certification and Assignment

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.

I certify that I, and/or my dependent(s), have insurance coverage with _____
Name of Insurance Company(ies)

and assign directly to **Dr. Karla M. Stanz** 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.

**Dr. Karla M. Stanz** 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.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____
Print Name of Patient, Parent, Guardian or Personal Representative

**Karla M. Stanz, D.M.D.**

**Karla M. Stanz, D.M.D.**
**William Penn Highway & Stones Crossing**
**3787 Nicholas Street**
**Easton, PA 18045**
**610-252-8558**

Please read the following information concerning composite restorations. If you have any questions, please feel free to ask at the desk.

My direct placed restoration will be done as a bonded resin-ceramic (composite).

**My insurance company may not cover all the cost** of this restoration, substituting payment for amalgam (mercury-silver).

I realize I am personally responsible for the difference in fee between an amalgam and composite restoration.

I have read and understand the above information concerning composite restorations.

Patient Signature_____
(parent if patient is a minor)

Date_____

Karla M. Stanz, D.M.D.
William Penn Hghwy & Stones Crossing
3787 Nicholas Street
Easton, PA 18045

{NAME OF PRACTICE}

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowedgement*

I, _____, have read 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)

_____

_____

_____

**Karla M. Stanz , D.M.D.**

# Financial Policy

Payment is expected at the time of services. We accept check, cash, or credit card (Visa, Master Card, American Express, Discover and Care Credit.)

INSURANCE: We are happy to take assignment of benefits for your insurance with the following stipulations:

1) A current PRIMARY dental insurance card must be brought at the time of the appointment or full payment will be expected.

2) Deductibles, as well as any percentages not covered by your insurance, must be paid at the time of treatment.

3) If payment is NOT received from your carrier within 60 DAYS, regardless of the reason, payment must be made by you in full within 10 DAYS of notification.

4) A social security number must be on file, in order for our office to accept assignment of benefits.

I also understand that I am responsible for payment of services rendered, and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the release of information necessary to process claims made by Karla M. Stanz, D.M.D. for services rendered to me. I authorize the use of this signature on all of my insurance submissions as well as authorize payment of insurance benefits to Karla M. Stanz, D.M.D.

In the event any unpaid balance is placed for collection, with any third party collection agency, and/or with an attorney to obtain judgments or otherwise satisfy payment of this account, all collections fees will be added to the total amount due. This amount shall include any costs incurred directly or indirectly by the provider to collect amounts owed under this agreement. Costs include but are not limited to, collection fees, late fees, and accrued interest. These costs and fees will reflect the actual costs incurred.

We have reserved your appointment time exclusively for you and would appreciate 48 hours notice. If you fail to do so a $50.00 cancellation fee will be charged.

I understand the above terms and conditions as indicated by my signature below.

Signature _____Date _____