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

Patient: _____ Preferred Name: _____
Last *First* *MI*

Address: _____ Home Phone: _____
Cell Phone: _____

_____ Date of Birth: _____
City *State* *Zip*

Social Security #: ___ - ___- ____

Email: _____

Gender: ☐ Male ☐ Female Family Status: ☐ Married ☐ Single ☐ Child ☐ Other

Emergency Contact: _____ Phone: _____

How did you hear about Stone Creek Dental?

☐ Location ☐ Mailer ☐ Insurance ☐ Internet ☐ Other _____

Would you like text appointment reminders? ☐ Yes ☐ No

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 Phone:_____

ID/Social #: _____ Group #: _____

Employer Name: _____ Phone: _____

Employer Address: _____

I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Initial: _____

Guarantor Information

Same as Insured? ☐ Yes ☐ No ☐ Other _____

Relationship to Insured? ☐ Self ☐ Spouse ☐ Child ☐ Other Phone: _____

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

Medical History

Who is your physician? _____

☐ *Allergy - Aspirin ☐ *Allergy - Codeine ☐ *Allergy - Gluten ☐ *Allergy - Latex
☐ *Allergy - Seasonal ☐ *Allergy - Sulfa ☐ *Allergy- Iodine ☐ *Allergy- Penicillin
☐ *Allergy-Epinephrine ☐ *Allergy-Erythromyci ☐ ADD/ADHD ☐ AIDS/HIV
☐ Abnormal Bleeding ☐ Anemia ☐ Anthrax ☐ Arthritis/Rheumatism
☐ Artificial Heart Val ☐ Artificial Joints ☐ Asthma ☐ Autism
☐ Back Surgery ☐ Bi-Polar ☐ Blood Disease ☐ Blood Transfusion
☐ Cancer/Chemo/Radiati ☐ Celiac Disease ☐ Congenital Heart Def ☐ Crohns
☐ Depression ☐ Diabetes I ☐ Diabetes II ☐ Dizziness
☐ Epilepsy/Seizures ☐ Fainting ☐ Fever Blisters/Cold ☐ Gallbladder Removal
☐ Gastric Bypass ☐ Glaucoma ☐ Head Injuries ☐ Heart Surgery
☐ Hemophilia ☐ Hepatitis A ☐ Hepatitis B ☐ Hepatitis C
☐ Herpes 1 (oral) ☐ Herpes II ☐ High Anxiety ☐ High Blood Pressure
☐ High Cholesterol ☐ Jaundice ☐ Jaw Pain ☐ Kidney Problems
☐ Kidney Stones ☐ Liver Disease ☐ Low Blood Pressure ☐ Lupus
☐ Mental Disorders ☐ Mitral Valve Prolaps ☐ Nausea following IV ☐ Neck Surgery
☐ Nervous Disorders ☐ Pacemaker ☐ Parkinsons ☐ Pregnancy
☐ Respiratory Problems ☐ Rheumatic Fever ☐ Rheumatism ☐ Severe/Freq Headache
☐ Shingles ☐ Shortness of Breath ☐ Sinus Problems ☐ Sjogren's syndrome
☐ Skin Rash ☐ Sleep Apnea ☐ Smoke/Chew tobacco ☐ Stomach Problems
☐ Stroke ☐ Substance Abuse ☐ Swelling of Feet/Ank ☐ Swollen Neck Glands
☐ Thyroid Problems ☐ Tonsillitis ☐ Tuberculosis ☐ Tumors ☐ Ulcers/Colitis Vertigo

Other Allergies: _____
_____

Please list any medications you are currently taking, one medication per line: _____
_____
_____
_____
_____

Do you take a blood thinner? (such as Aspirin, Coumadin, Pllavix) ☐ Yes ☐ No
Do you take an antibiotic premedication for your dental visits? ☐ Yes ☐ No Type: _____

I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

Initial: _____

Dental Information

What is your immediate concern? _____
_____

Previous Dentist Name and Phone Number: _____
_____

Date of most recent dental exam and dental x-rays: _____
_____

Is there anything about the appearance of your smile that you would like to change?
_____

Check all that apply:

- ☐ If any of the checked boxes need further explanation, please describe:
- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe: _____
_____
_____
_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that in the event any amount(s) is/are referred to a third party debt collection agency, I agree to pay a collection fee of 25%, interest, court costs, and reasonable attorney's fees.

Initial: _____

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

Name and Relationship to Patient: _____

Initial: _____

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 to my health/medications, insurance/financial information.

_____

SIGNATURE OF PATIENT, PARENT, GUARDIAN **DATE**