

## Patient Information

Date \_\_\_\_\_

Name of patient \_\_\_\_\_ M \_\_\_\_\_ F \_\_\_\_\_ SS# \_\_\_\_\_

Name of spouse or parent \_\_\_\_\_ SS# \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_

Date of Birth \_\_\_\_\_ Marital Status \_\_\_\_\_ Patient employed by \_\_\_\_\_

Home phone \_\_\_\_\_ Work phone \_\_\_\_\_ Cell phone \_\_\_\_\_

E-mail \_\_\_\_\_ How did you hear about us? \_\_\_\_\_

Emergency contact name \_\_\_\_\_ Phone number \_\_\_\_\_

## Primary Insurance Information

Name of Employee \_\_\_\_\_ SS# \_\_\_\_\_

Date of birth \_\_\_\_\_ Employer \_\_\_\_\_

Name of Insurance company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Your relationship \_\_\_\_\_ self \_\_\_\_\_ spouse \_\_\_\_\_ child

## Secondary Insurance Information

Name of Employee \_\_\_\_\_ SS# \_\_\_\_\_

Date of birth \_\_\_\_\_ Employer \_\_\_\_\_

Name of Insurance company \_\_\_\_\_ Group # \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Your relationship \_\_\_\_\_ self \_\_\_\_\_ spouse \_\_\_\_\_ child

# Dental History

When was your last dental visit? \_\_\_\_\_

With Whom? \_\_\_\_\_ Phone \_\_\_\_\_

When were your last x-rays taken and what kind? \_\_\_\_\_

Have you had your wisdom teeth out? \_\_\_\_\_ Are you missing any other teeth? \_\_\_\_\_

If yes, for how long? \_\_\_\_\_ Are they being replaced with an appliance? \_\_\_\_\_ Is it removable? \_\_\_\_\_

How old is it? \_\_\_\_\_ Do you wish to keep your teeth for a lifetime? \_\_\_\_\_

If you could change anything about your smile what would it be? \_\_\_\_\_

Are you happy with the color of your teeth? \_\_\_\_\_ If you could lighten them would you? \_\_\_\_\_

Have you ever been told you have gum disease? \_\_\_\_\_ Do your gums bleed while brushing? \_\_\_\_\_

Do you clench or grind your teeth? \_\_\_\_\_ Do your jaws ever feel tired or ache? \_\_\_\_\_

Have you ever had an unpleasant dental experience? \_\_\_\_\_

Are any of your teeth sensitive to heat \_\_\_\_\_ cold \_\_\_\_\_ sweets \_\_\_\_\_ chewing \_\_\_\_\_

Do you have any questions regarding dentistry or your dental health? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



## **Signatures**

**My patient information and medical history is accurate and complete to the best of my knowledge. I will not hold Dr. Stamas or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

## **Assignment and Release for Insurance**

**I, the undersigned, if I have insurance, assign payments directly to Dr. Stamas and Associates. All 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 hereby authorize Dr. Stamas and Associates to release all information necessary to secure the payment of benefits. I authorize the use of this signature on my insurance submissions whether manual, electronic, or over the internet.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

## **Minor/Child Consent**

**I, being the parent or guardian of \_\_\_\_\_ do hereby request and authorize the dental staff to perform any necessary dental services on my child, including but not limited to fluoride, x-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the appointment when the treatment is rendered.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

## **Financial Agreement**

**I acknowledge that payment is due at the time of treatment, unless other arrangements have been made prior to my appointment. I agree that parents/guardians are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges not covered by insurance. I also understand that a balance not paid within 30 days is subject to finance charges. I am responsible for any accrued interest on the remaining balance due. This includes any collection costs and attorney fees accrued to collect on my account.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**

## **Consent for use/Disclosure of Health Information**

**By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payments and health care operations. Our office may also be required to disclose your information to dental specialists, law enforcement agencies, and collection services. Our notice of privacy practices provides more details on our treatment, payment activities and health care operations. You have the right to access your health information upon written request. I have read the contents of this consent form and the notice of privacy practices. I understand that I am giving Dr. Stamas and associates my consent to use and disclose my personal and health care information to carry out treatment, payment activities (including outside collections) and health care operations.**

**Signature \_\_\_\_\_ Date \_\_\_\_\_**