Date of Appointment____________

___________________________________ __ _/__/__

Name Gender DOB

Social Sec # __ __ __-__ __- __ __ __ __

Reason for Visit

What brings you to the office today?

- [ ] Professional Cleaning and Examination
- [ ] Consult (Second Opinion)
- [ ] Emergency
- [ ] Other

Allergies

Are you allergic to any of the following?

Adhesive Tape Antibiotics Latex

Codeine Aspirin Iodine

Do you have any other allergies?

Name_____________ Reaction___________

Hospitalizations & Surgeries

Reason:_________________________ Date:_____

Reason:_________________________ Date:____

Current Medications

Are you currently taking any blood thinners?

- [ ] **Yes**
- [ ] **No**

What Medications are you currently taking?

Name_______________ Dosage______ Frequency______

Name_______________ Dosage______ Frequency______

Name_______________ Dosage______ Frequency______

Dental History

When was your last dental exam?

Date____________________

When were your last dental x-rays taken?

Date____________________

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

times/day__________ # of times/day_________

Have you ever had periodontal (gum) treatments?

Yes [ ] No [ ]

Do you have any of the following?

Bad BreathDry Mouth Partials

Bleeding Gums Difficulty Chewing Sensitivity to Cold

Blisters on Mouth Ear Pain Sensitivity to Heat

Do you grind your teeth?

☐ Yes ☐ No

Have you ever had orthodontic (Braces) treatment?

☐ Yes ☐ No

Broken Fillings	Jaw Pain	Sensitivity to Sweets
Clicking Jaw	Loose Teeth	Sensitivity to Pressure
Dentures	Mouth Pain	Swollen Gums
Difficulty Opening or Closing		Mouth Sores

Past Medical History

Have you ever had any of the following?

Alcoholism	Bleeding Disorder	Eating Disorder	High Cholesterol	Migraines	Stomach Ulcer
Allergies	Blood Disease	Epilepsy	Joint Disorder	Osteoporosis	Substance Abuse
Anemia	Blood Transfusion	Hay Fever	Kidney Disorder	Pacemaker	Thyroid Disorder
Anxiety Disorder	Bowel Disorder	Heart Disease	Liver Disorder	Rheumatic Fever	Tuberculosis
Arthritis	Cancer	Heart Problems	Lung Disease	Sinus Problems	Venereal Disease
Asthma	Diabetes	Hepatitis A, B, or C	Lupus	Skin Disorder	
AIDS/HIV	Depression	Hypertension	Measles	Stroke	

Lifestyle Factors

Have you ever smoked?

☐ Yes ☐ No # of Years____________ # packs/day_________

Do you smoke now?

☐ Yes ☐ No # Packs/day__________

Do you use recreational drugs?

☐ Yes ☐ No Types?_____________ # times/week______

How much alcohol do you drink per week?

drinks /week ______________________

How much caffeine do you drink per day?

drinks/day _______________________

Women Only

Are you pregnant? Yes ☐ No ☐

Are you breastfeeding? Yes ☐ No ☐

Authorization for Signature on File

Release of Information/Financial Responsibility/Authorization for Payment

I (name of patient) _________________________________ and/or (name of insured)

___________________________________ hereby authorize Sterling Dentistry PLLC to affix my name to any and all claims or documents as related to any and all health benefits due me and my dependents through my employment with (name of employer) ____. I herby authorize payment of dental benefits otherwise payable to me directly to the office above. I have reviewed the treatment plan and fees. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law. I authorize release of any information relating to the claim.

Signature of Patient (Parent or Guardian if minor):______________________________

Signature of Insured: __________________________________ Today's Date: ________

Office Policy

Please Read and sign at the bottom, acknowledging that you were informed of these policies. Let us know if you have any questions about our Office Policies. Thank you.

Financial Policy

Thank you for choosing **Sterling Dentistry PLLC** to serve your dental care needs. We provide high-quality dental care to our patients and are committed to your treatment being successful. Please understand that your financial obligation is considered a part of your treatment. In the interest of good dental care practice, it is desirable to establish a credit policy to avoid misunderstandings. To assist our patients we offer the following methods for taking care of their account in our office.

- On your first visit we expect you to supply our office with your insurance information and photo ID card. If any changes should occur during the time you are a patient, it is your responsibility to inform our office with any changes. Our office will not be responsible for claims submitted to insurance companies by which you are no longer covered.
- New patients are required to pay for services in full on their first visit. Patients are required to pay their deductible and co-payments at the time of each visit.
- While we accept most PPO plans and are happy to aid in submission of your claims, it is your responsibility to read your policy and be aware of services covered or not covered by your individual plan.
- As a courtesy, we will gladly bill your insurance when you provide us with the current information and any necessary forms. Often times we are able to contact your insurance provider prior to your appointment and estimate your portion of the bill. We ask that you either pay your portion of the bill at the time of service, or that a suitable written financial agreement be reached at the time of service. Even though you may have an insurance claim pending, you may receive a monthly statement for the outstanding balance on your account until it is paid in full. We cannot accept responsibility for collecting an insurance claim after 60 days or for negotiating a disputed claim. Insurance policies are a contract between you , your employer and the insurance carrier. Please be aware that some, and perhaps all of the services rendered may not be covered under your individual insurance policy. You are ultimately responsible for payment of your account.
- If no payment is receiver on an account after two monthly statements our office will make every effort to contact the responsible party. If the party responsible cannot be reached, a third bill will be sent indicating "This will be the final notice for payment". If the party fails to contact our office after receiving such notice, the account will be sent to a collection agency.
- Financial options are available to all patients. Please feel free to ask one of our office personnel.

Failed or Cancelled Appointments

If an appointment has been reserved for your you, we kindly ask that patients give us twenty-four hours notice for cancellations; otherwise, we reserve the right to charge a minimum of $60.00 per half hour, which is currently our broken appointment fee. If the appointment is with a specialist, the minimum fee is $120.00 per half hour visits. The length of time reserved and the number of prior failed appointments determines your charge. We will not offer appointments to patients who fail multiple appointments without having given us proper notice.

Estimates and Fees

After X-rays and examination, you are entitled to and should ask for an estimate of fees to cover your treatment. All estimates are based upon conditions viewed at the time of diagnosis; unforeseen circumstances such as pulpal therapy or cracked teeth could alter an estimated fee. It is customary to pay for dental services when they are rendered. There is a service charge on all unpaid accounts.

Delinquent Accounts

Delinquent accounts will have to be turned over to a Credit Reporting Collection Agency.

Signature:____ **Date:**___________________