781 Far Hills Drive
Suite 500
New Freedom, PA 17349

STONEBRIDGE DENTAL

Phone: 717-235-8234
Fax: 717-235-8266
Email: info@stonebridgedental.net
Web: stonebridgedental.net

Patient Registration

Please complete both pages with the following confidential information.

If the appointment is for you start here:

DATE _____

LAST NAME _____ FIRST _____ M.I. ____ PREFER TO BE CALLED BY: _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ FAX _____ EMAIL _____

BIRTH DATE _____ AGE ____ ○ MALE ○ FEMALE ○ MARRIED ○ SINGLE ○ DIVORCED ○ WIDOWED

SOCIAL SECURITY NO. _____

If the appointment is for your child start here:

DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ FAX _____ EMAIL _____

BIRTH DATE _____ AGE ____ ○ MALE ○ FEMALE SCHOOL _____

SOCIAL SECURITY NO. _____ *If your child's last name and/or address are not the same as yours, fill in the top box with your address.*

Dental Insurance Primary Carrier:

INSURANCE COMPANY _____ BIRTH DATE _____ PATIENT RELATIONSHIP _____

GROUP NO . _____ INSURED'S I.D. NO. _____

EMPLOYER NAME _____ INSURED'S SOCIAL SECURITY NO. _____

INSURED'S NAME _____

Dental Insurance Secondary Carrier:

INSURANCE COMPANY _____ BIRTH DATE _____ PATIENT RELATIONSHIP _____

GROUP NO. _____ INSURED'S I.D. NO. _____

EMPLOYER NAME _____ INSURED'S SOCIAL SECURITY NO. _____

INSURED'S NAME _____

ACCOUNT INFORMATION

Person financially responsible for account:

NAME _____ PATIENT RELATIONSHIP _____ SOCIAL SECURITY NO. _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. _____

You:

NAME _____ OCCUPATION _____

EMPLOYER'S NAME _____ ADDRESS _____ CITY _____

PHONE _____ FAX _____

Your Spouse:

NAME _____ OCCUPATION _____

EMPLOYER'S NAME _____ ADDRESS _____ CITY _____

PHONE _____ FAX _____

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT AT OUR OFFICE?

NAME _____ RELATIONSHIP _____

YOU WERE REFERRED TO US BY _____

YOUR FORMER ADDRESS _____ CITY _____ STATE _____ ZIP _____

PERSON TO CONTACT FOR EMERGENCY _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. _____

CLOSEST RELATIVE NOT LIVING WITH YOU _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PHONE NO. _____

Upon scheduling appointments, we have reserved this time especially for you. If you are unable to keep this appointment, please give 24-hour notice. Be advised that there may be a charge for the missed appointment.

Consent for Treatment

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs. and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of *(name of patient)* _____ 's dental needs.
2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.
3. I agree to the use of anaesthetics, sedatives and other medication as necessary. I fully understand that using anaesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
4. I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.
5. I agree to be responsible for payment of all services rendered on my behalf or my dependants. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

PATIENT'S SIGNATURE _____ DATE _____ WITNESS _____

PARENT/RESPONSIBLE PARTY'S SIGNATURE _____ RELATIONSHIP TO PATIENT _____

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Medical History

PATIENT NAME _____ PATIENT ACCOUNT NO. _____ MEDICAL ALERT _____

1. HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS? ◯ YES ◯ NO

IF YES, FOR WHAT? _____

PHYSICIAN'S NAME _____ PHONE _____ ADDRESS _____

2. HAVE YOU TAKEN ANY MEDICATION OR DRUGS DURING THE PAST TWO YEARS? ◯ YES ◯ NO

3. ARE YOU CURRENTLY TAKING ANY MEDICATION OR DRUGS, INCLUDING REGULAR DOSES OF ASPIRIN OR OVER-THE-COUNTER HERBAL MEDICINES? ◯ YES ◯ NO

IF YES, PLEASE LIST NAME AND DOSAGE: _____

4. HAVE YOU EVER TAKEN ANY PRESCRIPTION DRUGS FOR WEIGHT LOSS, INCLUDING FEN-PHEN (FENFLURAMINE-PHENTERMINE); PONDIMEN (FENFLURAMINE); AND REDUX (DEXFENFLURAMINE)? ◯ YES ◯ NO IF YES TO THE ABOVE, DID YOU HAVE A MEDICAL EXAM FOR HEART ISSUES? ◯ YES ◯ NO

5. ARE YOU AWARE OF HAVING AN ALLERGIC (OR ADVERSE) REACTION TO ANY MEDICATION OR SUBSTANCE? ◯ YES ◯ NO

IF YES, PLEASE LIST: _____

6. HAVE YOU BEEN A PATIENT IN THE HOSPITAL DURING THE PAST FIVE YEARS? ◯ YES ◯ NO

7. INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD, OR HAVE AT PRESENT. CIRCLE "YES" OR "NO" FOR EACH ITEM.

HEART (SURGERY, DISEASE, ATTACK)	YES	NO	ULCERS	YES	NO	HEPATITIS *(CHECK ONE)* A☐ B☐ C☐	YES	NO
CHEST PAIN	YES	NO	DIABETES	YES	NO	VENEREAL DISEASE	YES	NO
CONGENITAL HEART DISEASE	YES	NO	THYROID PROBLEMS	YES	NO	A.I.D.S.	YES	NO
HEART MURMUR	YES	NO	GLAUCOMA	YES	NO	H.I.V. POSITIVE	YES	NO
HIGH BLOOD PRESSURE	YES	NO	CONTACT LENSES	YES	NO	COLD SORES/FEVER BLISTERS	YES	NO
MITRAL VALVE PROLAPSE	YES	NO	EMPHYSEMA	YES	NO	BLOOD TRANSFUSION	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	CHRONIC COUGH	YES	NO	HEMOPHILIA	YES	NO
HEART PACEMAKER	YES	NO	TUBERCULOSIS	YES	NO	SICKLE CELL DISEASE	YES	NO
RHEUMATIC FEVER	YES	NO	ASTHMA	YES	NO	BRUISE EASILY	YES	NO
ARTHRITIS/RHEUMATISM	YES	NO	HAY FEVER	YES	NO	LIVER DISEASE	YES	NO
CORTISONE MEDICINE	YES	NO	LATEX SENSITIVITY	YES	NO	YELLOW JAUNDICE	YES	NO
SWOLLEN ANKLES	YES	NO	ALLERGIES OR HIVES	YES	NO	NEUROLOGICAL DISORDERS	YES	NO
STROKE	YES	NO	SINUS TROUBLE	YES	NO	EPILEPSY OR SEIZURES	YES	NO
DIET (SPECIAL/RESTRICTED	YES	NO	RADIATION THERAPY	YES	NO	FAINTING OR DIZZY SPELLS	YES	NO
ARTIFICIAL JOINTS (HIP, KNEE, ETC.)	YES	NO	CHEMOTHERAPY	YES	NO	NERVOUS/ANXIOUS	YES	NO
KIDNEY TROUBLE	YES	NO	TUMORS	YES	NO	PSYCHIATRIC/PSYCHOLOGICAL CARE	YES	NO

8. DO YOU USE MORE THAN TWO PILLOWS TO SLEEP? ◯ YES ◯ NO

9. HAVE YOU LOST OR GAINED MORE THAN 10 POUNDS IN THE PAST YEAR? ◯ YES ◯ NO

10. DO YOU HAVE OR HAVE YOU HAD ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED? ◯ YES ◯ NO

IF YES,PLEASE LIST: _____

11. ARE YOU PREGNANT OR MAY YOU BE PREGNANT? ◯ YES, __ MONTHS ◯ NO NURSING? ◯ YES ◯ NO DO YOU USE BIRTH CONTROL MEDICATIONS? ◯ YES ◯ NO

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the dentist of any changes in my health or medication.

PATIENT/GUARDIAN SIGNATURE _____ DATE _____

HISTORY REVIEW

DENTIST SIGNATURE _____ DATE _____

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Dental History

PATIENT NAME _____ PATIENT ACCOUNT NO. _____ MEDICAL ALERT _____

Welcome! So that we may provide you with the best possible care please complete both sides of this form. All information is completely confidential.

WHAT IS THE REASON FOR YOUR VISIT TODAY? _____

DATE OF LAST DENTAL VISIT _____ LAST DENTAL CLEANING _____ LAST FULL MOUTH X-RAYS _____

WHAT WAS DONE AT YOUR LAST DENTAL VISIT? _____

PREVIOUS DENTIST NAME _____ TELEPHONE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOW OFTEN DO YOU HAVE DENTAL EXAMINATIONS? _____ HOW OFTEN DO YOU BRUSH YOUR TEETH? _____ HOW OFTEN DO YOU FLOSS? _____

HAVE YOU EVER USED OR CURRENTLY USE TOPICAL FLUORIDE? ○ YES ○ NO

WHAT OTHER DENTAL AIDS DO YOU USE? (LNTERPLAK, TOOTHPICK, ETC.) _____

DO YOU HAVE ANY DENTAL PROBLEMS NOW? ○ YES ○ NO

IF YES, PLEASE DESCRIBE: _____

ARE ANY OF YOUR TEETH SENSITIVE TO:

HOT OR COLD?	○ YES	○ NO
SWEETS?	○ YES	○ NO
BITING OR CHEWING?	○ YES	○ NO
HAVE YOU NOTICED ANY MOUTH ODORS OR BAD TASTES?	○ YES	○ NO
DO YOU FREQUENTLY GET COLD SORES, BLISTERS OR ANY OTHER ORAL LESIONS?	○ YES	○ NO
DO YOUR GUMS BLEED OR HURT?	○ YES	○ NO
HAVE YOUR PARENTS EXPERIENCED GUM DISEASE OR TOOTH LOSS?	○ YES	○ NO
HAVE YOU NOTICED ANY LOOSE TEETH OR CHANGE IN YOUR BITE?	○ YES	○ NO
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH? IF YES, WHERE?	○ YES	○ NO

DO YOU:

CLENCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP?	○ YES	○ NO
BITE YOUR LIPS OR CHEEKS REGULARLY?	○ YES	○ NO
HOLD FOREIGN OBJECTS WITH YOUR TEETH? (PENCILS, PIPE, PINS, NAILS, FINGERNAILS)	○ YES	○ NO
MOUTH BREATHE WHILE AWAKE OR ASLEEP?	○ YES	○ NO
HAVE TIRED JAWS, ESPECIALLY IN THE MORNING?	○ YES	○ NO
SNORE OR HAVE ANY OTHER SLEEPING DISORDERS?	○ YES	○ NO
SMOKE/CHEW TOBACCO OR USE OTHER TOBACCO PRODUCTS?	○ YES	○ NO

HAVE YOU EVER HAD:

ORTHODONTIC TREATMENT?	○ YES	○ NO
ORAL SURGERY?	○ YES	○ NO
PERIODONTAL TREATMENT?	○ YES	○ NO
YOUR TEETH GROUND OR THE BITE ADJUSTED?	○ YES	○ NO
A BITE PLATE OR MOUTH GUARD?	○ YES	○ NO
A SERIOUS INJURY TO THE MOUTH OR HEAD? IF SO, PLEASE DESCRIBE, INCLUDING CAUSE:	○ YES	○ NO

HAVE YOU EXPERIENCED:

CLICKING OR POPPING OF THE JAW?	○ YES	○ NO
PAIN? (JOINT, EAR, SIDE OF FACE)	○ YES	○ NO
DIFFICULTY IN OPENING OR CLOSING THE MOUTH?	○ YES	○ NO
DIFFICULTY IN CHEWING ON EITHER SIDE OF THE MOUTH?	○ YES	○ NO
HEADACHES, NECK ACHES OR SHOULDER ACHES?	○ YES	○ NO
SORE MUSCLES (NECK, SHOULDERS)?	○ YES	○ NO

ARE YOU SATISFIED WITH YOUR TEETH'S APPEARANCE?	○ YES	○ NO
WOULD YOU LIKE TO KEEP ALL OF YOUR TEETH ALL OF YOUR LIFE?	○ YES	○ NO
DO YOU FEEL NERVOUS ABOUT HAVING DENTAL TREATMENT? IF SO, WHAT IS YOUR BIGGEST CONCERN?	○ YES	○ NO
HAVE YOU EVER HAD AN UPSETTING DENTAL EXPERIENCE? IF YES, PLEASE DESCRIBE:	○ YES	○ NO

HAVE YOU EVER BEEN TOLD TO TAKE A PRE-MEDICATION PRIOR TO DENTAL TREATMENT? ○ YES ○ NO

IS THERE ANYTHING ELSE ABOUT HAVING DENTAL TREATMENT THAT YOU WOULD LIKE US TO KNOW? ○ YES ○ NO

IF YES, PLEASE DESCRIBE _____

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Financial Policy Letter

We at Stonebridge Dental are proud to be a part of a team whose primary mission is to deliver the finest and most comprehensive dental care services today. In order to assist you with your health care investment, we are providing the following payments options.

Payment: Payment is due at the time of service. We do accept cash, personal checks with current date, major credit cards, debit cards and third party financing through CareCredit.

Insurance: As a courtesy to our patients, we are happy to file your claims on your behalf. We will make every reasonable effort to collect covered amounts from your insurance company. Deductibles, co-payments and non-covered amounts are due at the time services are rendered. All estimates quoted are based upon information provided to us by your insurance company and are estimates only and are not a guarantee of payment. The patient is ultimately responsible for all charges incurred. Insurance companies are required by law to pay claims within 30 days. After 60 days, any unpaid claims will be resubmitted by our office and we ask that you follow-up as well. After 90 days, we ask that you pay in full and have your insurance company reimburse you. We will be happy to provide any information or documentation you may require. Our first and only priority is our patients and the quality of care. The negotiation of benefits is between you, your employer and insurance company.

Returned Checks: All returned checks are subject to a $30.00 returned check fee. Any unpaid returned checks will be forwarded to the District Attorney for collection.

Delinquent Accounts: Accounts over 90 days past due will be referred out for collection and the patient is responsible for any fees associated with that.

Cancellations: It is the philosophy of our office to provide optimal patient care. All patients are seen by appointment only and are scheduled with your individual needs in mind. This allows us to focus our efforts on caring and treating our patients to the best of our abilities. We do require 24 hours notice for cancellations and reschedules. This is necessary to allow us adequate time to notify patients who are on a waiting list for the first available appointment. We are then also able to offer all our patients' the same exceptional standard of care. A fee of $50.00 will be charged for failed or cancelled appointments with less than 24 hours notice. Please also be advised that our courtesy text reminders and email communications are not to be used for cancelling appointments. These are courtesy reminders that are opted in or out of directly by the patient.

Financing Options: Ask our team how we can help you with your financial needs. We offer some 0% interest plans through CareCredit. We will be happy to help you with this. Financing your treatment will allow you to begin your treatment immediately and spread the cost over a period of time.

I have read the above and understand and agree to these terms. I hereby authorize the release of any dental information necessary to process insurance claims. I authorize the payment of benefits to be directly sent to STONEBRIDGE DENTAL.

Patient or Responsible Party _____ Date _____

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Patient HIPAA Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Information Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you, Stonebridge Dental, to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payer (e.g. My insurance company);
- The day-to-day healthcare operations of Stonebridge Dental's healthcare practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operation, and that you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signature of Patient _____ Date _____

Print Patient's Name _____

Relationship to Patient _____