STONEBRIDGE
RANCH DENTISTRY

NEW PATIENT INFORMATION

Patient Name:_____ DOB:_____

Address:_____

Phone:_____ Email:_____

Please provide your email address to receive appointment reminders, office promotions, etc. Your address is never given or sold to outside vendors.

Please circle one of the following: Married Widowed Single Separated Divorced Minor Sex: M F

Patient Employer/School:_____ Occupation:_____ Phone:_____

In case of emergency, who should be notified?_____ Phone:_____

Please provide the name of any person or persons you wish to grant permission to Stonebridge Ranch Dentistry the ability to discuss personal, insurance, financial, or dental treatment plan information with. Please indicate relationship (i.e. spouse, parent, guardian, other relative, etc.)

Name:_____ Relationship:_____ Phone:_____

PRIMARY DENTAL INSURANCE

Policy Holder:_____ Relation to Patient:_____

DOB:_____ ID#/SSN:_____ Employer:_____ Occupation:_____

Insurance Company:_____ Group #:_____ Subscriber #:_____

Provider Contact Phone #:_____

Insurance Authorization

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Stonebridge Ranch Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understan that I am financially responsible for all charges whether or not paid by insurance. I authorize use of my signature on all insurance submissions. Stonebridge Ranch Dentistry may use my health care information and may disclose such information to the above named insurance company(ies) and their agants 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:_____

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DENTAL HISTORY

Name of previous dentist:_____Date of last visit:_____Last cleaning:_____

Are your teeth sensitve to hot, cold, sweets, or pressure?	Yes	No
Are there any areas that are hard to floss?	Yes	No
Do you have frequent headaches?	Yes	No
Do you experience popping or clicking upon opening or closing?	Yes	No
Do your facial muscles or jaw ever get tired or sore after chewing, sleeping, stress, etc.?	Yes	No
Do you experience facial muscle pain while chewing or when you wake up?	Yes	No
Do your gums ever bleed when you brush or floss?	Yes	No
Have your gums receded or pulled away from your teeth?	Yes	No
Do you have bad breath?	Yes	No

YOUR SMILE

Do you feel your teeth are crooked?	Yes	No
If so, does this bother you?	Yes	No
Have you had any cosmetic dentistry?	Yes	No
Would you like to have whiter teeth?	Yes	No

Is there anything you feel could make your smile better?_____

What is your goal for your dental care? Maintaining your dental health Cosmetic Treating only tooth pain

Other:_____

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MEDICAL HISTORY FOR: _____

(Please print patient's full name)

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Y N	Have you ever been hospitalized or had a major operation?	Y N
Have you ever had a serious head or neck injury?	Y N	Are you taking any medications, pills, or drugs?	Y N
Are you on a special diet?	Y N	Do you use tobacco?	Y N
Do you use controlled substances?	Y N	Do you take, or have you taken, Phen-Fen or Redux?	Y N

If yes to any of the above questions, please explain: _____

Women: Are you pregnant/trying to get pregnant? Y N Taking oral contraceptives? Y N Nursing? Y N

Do you have or have you had any of the below conditions?

AIDS / HIV Positive	Y N	Excessive Bleeding	Y N	Pain in Jaw Joints	Y N
Alzheimer's Disease	Y N	Excessive Thirst	Y N	Parathyroid Disease	Y N
Anaphylaxis	Y N	Fainting Spells / Dizziness	Y N	Psychiatric Care	Y N
Anemia	Y N	Frequent Cough	Y N	Radiation Treatments	Y N
Angina	Y N	Frequent Diarrhea	Y N	Recent Weight Loss	Y N
Arthritis / Gout	Y N	Frequent Headaches	Y N	Renal Dialysis	Y N
Artificial Heart Valve	Y N	Genital Herpes	Y N	Rheumatic Fever	Y N
Artificial Joint	Y N	Glaucoma	Y N	Rheumatism	Y N
Asthma	Y N	Hay Fever	Y N	Scarlet Fever	Y N
Blood Disease	Y N	Heart Attack / Failure	Y N	Shingles	Y N
Blood Transfusion	Y N	Heart Murmur	Y N	Sickle Cell Disease	Y N
Breathing Problem	Y N	Heart Pace Maker	Y N	Sinus Trouble	Y N
Bruise Easily	Y N	Heart Trouble / Disease	Y N	Sleep Apnea	Y N
Cancer	Y N	Hemophilia	Y N	Stomach / Intestinal Disease	Y N
Chemotherapy	Y N	Hepatitis A	Y N	Stroke	Y N
Chest Pains	Y N	Hepatitis B or C	Y N	Swelling of Limbs	Y N
Cold Sores / Fever Blisters	Y N	Herpes	Y N	Thyroid Disease	Y N
Congenital Heart Disorder	Y N	High Blood Pressure	Y N	Tonsillitis	Y N
Convulsions	Y N	Hives or Rash	Y N	Tuberculosis	Y N
Cortisone Medicine	Y N	Hypoglycemia	Y N	Tumors or Growths	Y N
Diabetes	Y N	Irregular Heartbeat	Y N	Ulcers	Y N
Drug Addiction	Y N	Kidney Problems	Y N	Venereal Disease	Y N
Easily Winded	Y N	Leukemia	Y N	Yellow Jaundice	Y N
Emphysema	Y N	Liver Disease	Y N		
Epilepsy or Seizures	Y N	Mitral Valve Disease	Y N		

If you answered yes to any of the above conditions, or if you have had another serious illness not listed above, please explain:

_____

_____

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other: _____

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 medical status.

_____ _____

Patient or parent signature Date

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FINANCIAL POLICY ACKNOWLEDGEMENT

We at Stonebridge Ranch Dentistry 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 payment options.

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

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 (including fees above your insurance company's usual and customary fee schedule) 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 or deny claims within 45 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 $35.00 returned check fee.

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 of our patients' the same exceptional standard of care. A fee of $25 will be charged for failed or cancelled appointments with less than 24 hours notice.

FINANCING: Ask our team how we can help you with your financial needs. We offer some 0% interest plans through Care Credit. 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 to STONEBRIDGE RANCH DENTISTRY.

Patient/Responsible Party:_____ Date:_____