STUART PROSTHETIC
DENTISTRY

Welcome To Our Office!

Please aid us in giving you exceptional care by completing the necessary forms for us. If you have any questions or need assistance, please don't hesitate to ask us, we will be happy to help.

Patient Information

Name: Last_____ First_____ MI_____ Preferred name_____ Date: _____
Home Address: _____ City_____ State_____ Zip_____
Phone: Home_____ Cell_____ Work_____
E-Mail Address: _____ Can we confirm appointments by E-mail? _____ by Text? _____
Social Security #: _____ Birth Date: _____ Age: _____ Gender: _____
Occupation: _____ Employer: _____ Name of school if student: _____
Business Address: _____ City_____ State_____ Zip_____
Check appropriate: _____Minor _____Single _____Married _____Divorced _____Widowed _____Separated
Emergency contact: _____ Phone: Home_____ Cell_____ Relationship: _____
If you are completing this for another person, what is your relationship to that person? _____
How did you learn about our office? _____ Whom may we thank for referring you to our office? _____
Name of responsible party: _____ Phone: Home_____ Cell_____ Relationship: _____

Medical Information

	Yes	No	DK
Are you now under the care of a physician?.....	☐	☐	☐
Physician name: _____ Phone: _____			
Are you in good health?.....	☐	☐	☐
Date of last physical exam: _____			
Has there been any change in your general health within the past year?.....	☐	☐	☐
If yes, what was/is being treated? _____			
Have you had a serious illness, operation or been hospitalized in the past 5 years?.....	☐	☐	☐
If yes, what was the illness? _____			
Do you use tobacco (smoking, snuff, chew)?.....	☐	☐	☐
Do you drink alcoholic beverages?.....	☐	☐	☐
If yes, how much in the last 24 hours? _____			

	Yes	No	DK
Bisphosphonates. Have you ever received, or are you currently receiving, a medication for treatment of bone cancer or osteoporosis? (Ex: Actonel, Aredia, Boniva, Didronel, Fosamax, Zometa).....	☐	☐	☐
Blood Thinners. Do you take blood thinners?.....	☐	☐	☐
Joint Replacement. Have you had an orthopedic total joint replacement (hip, knee, elbow, finger)?.....	☐	☐	☐
Date: _____ If yes, any complications: _____			
Women Only - Are you:			
Pregnant?.....	☐	☐	☐
Number of weeks?_____			
Taking birth control pills or hormone replacement?.....	☐	☐	☐
Nursing?.....	☐	☐	☐

Medications: Please list all of your current medications, including prescription, over the counter, vitamins, natural or herbal preparations, and/or diet supplements: _____
_____
_____

Allergies – Are you allergic to or have you had a reaction to: (To all **Yes** responses, specify the type of reaction)

	Yes	No	DK
Local anesthetics_____	☐	☐	☐
Aspirin_____	☐	☐	☐
Penicillin or other antibiotics_____	☐	☐	☐
Sulfa drugs_____	☐	☐	☐

	Yes	No	DK
Codeine or other narcotics_____	☐	☐	☐
Latex (rubber)_____	☐	☐	☐
Metals_____	☐	☐	☐
Others_____	☐	☐	☐

Antibiotic Prophylaxis:
Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? _____
Name of physician or dentist making recommendation: _____ Phone: _____

Have you ever had any of the following? Please check those that apply

	Yes	No	DK		Yes	No	DK		Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐	Blood transfusion	☐	☐	☐	Ulcers	☐	☐	☐
Previous infective endocarditis	☐	☐	☐	If yes, date:_____	☐	☐	☐	Thyroid problems	☐	☐	☐
Congenital heart disease (CHD):				Hemophilia	☐	☐	☐	Stroke	☐	☐	☐
Unrepaired, cyanotic CHD	☐	☐	☐	AIDS or HIV infection	☐	☐	☐	Glaucoma	☐	☐	☐
Repaired in last 6 months	☐	☐	☐	Arthritis	☐	☐	☐	Hepatitis/Liver disease	☐	☐	☐
Repaired CHD w/ residual defects	☐	☐	☐	Autoimmune disease	☐	☐	☐	Epilepsy/Fainting spells	☐	☐	☐
				Rheumatoid arthritis	☐	☐	☐	Neurologic disorders			
Cardiovascular disease	☐	☐	☐	Systemic lupus erythematosus	☐	☐	☐	If yes, please specify:_____	☐	☐	☐
Angina	☐	☐	☐	Asthma	☐	☐	☐	Sleep disorder	☐	☐	☐
Arteriosclerosis	☐	☐	☐	Bronchitis	☐	☐	☐	Sleep apnea	☐	☐	☐
Congestive heart failure	☐	☐	☐	Emphysema	☐	☐	☐	Mental health disorder			
Damaged heart valves	☐	☐	☐	Sinus problems	☐	☐	☐	If yes, please specify:_____	☐	☐	☐
Heart attack	☐	☐	☐	Tuberculosis	☐	☐	☐	Recurrent infections			
Heart murmur	☐	☐	☐	Cancer/Chemotherapy/				If yes, please specify:_____	☐	☐	☐
Low blood pressure	☐	☐	☐	Radiation treatment	☐	☐	☐	Kidney problems	☐	☐	☐
High blood pressure	☐	☐	☐	Chest pain	☐	☐	☐	Osteoporosis	☐	☐	☐
Mitral valve prolapse	☐	☐	☐	Chronic Pain	☐	☐	☐	Severe headaches/migraines	☐	☐	☐
Pacemaker	☐	☐	☐	Diabetes – Type I or Type II	☐	☐	☐	Sexually transmitted disease	☐	☐	☐
Rheumatic fever	☐	☐	☐	Eating disorder	☐	☐	☐	Excessive urination	☐	☐	☐
Abnormal bleeding	☐	☐	☐	Gastrointestinal disease	☐	☐	☐	Use of oxygen tank	☐	☐	☐
Anemia	☐	☐	☐	GE reflux/heartburn	☐	☐	☐				

Do you have any disease, medical condition, or problem not listed above that you think we should know about?_____
_____

Dental Information

Chief Complaint (Reason for today's visit):_____
Date of last dental visit:_____ Date of last dental x-rays:_____ Date of last dental exam:_____
What was done at your last dental visit:_____ Complications?_____
Routineness of dental visits: ☐3 mo. ☐4 mo. ☐6 mo. ☐12 mo. ☐Not routinely
Routineness of brushing: ☐3 or more times per day ☐Twice per day ☐Once per day ☐Not routinely
Routineness of flossing: ☐3 or more times per day ☐Twice per day ☐Once per day ☐Not routinely
How do you feel about the appearance of your teeth?_____
How do you feel about the function of your teeth?_____

	Yes	No	DK		Yes	No	DK
Are you currently experiencing dental pain or discomfort?	☐	☐	☐	Do you use an electric toothbrush?	☐	☐	☐
Have you had any complications associated with previous dental treatment?	☐	☐	☐	Do you have jaw or TMJ pain?	☐	☐	☐
If yes, please specify:_____				Do you have clicking, popping, or locking of the jaw?	☐	☐	☐
Do your gums bleed or are they painful when brushing or flossing?	☐	☐	☐	Do you brux (grind or clench) your teeth?	☐	☐	☐
Have you ever been told that you have bone loss around your teeth?	☐	☐	☐	Do you currently wear a bite appliance/night guard?	☐	☐	☐
Have you ever experienced gum recession?	☐	☐	☐	Have you ever worn a bite appliance/night guard?	☐	☐	☐
Have you ever had any teeth become loose on their own (without injury)?	☐	☐	☐	Does food catch between your teeth?	☐	☐	☐
Do you experience halitosis (bad breath)?	☐	☐	☐	Are your teeth sensitive to hot, cold, sweets, or pressure?	☐	☐	☐
Have you had any periodontal (gum) treatments?	☐	☐	☐	Have you ever whitened or bleached your teeth?	☐	☐	☐
Is your mouth dry?	☐	☐	☐	Have you ever had orthodontic treatment (braces)?	☐	☐	☐
Do you have sores or ulcers in your mouth?	☐	☐	☐	Do you wear orthodontic retainers?	☐	☐	☐
Have you ever had a serious injury to your mouth?	☐	☐	☐	Do you wear complete or partial dentures?	☐	☐	☐
				Have you ever seen a prosthodontist?	☐	☐	☐

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. If I ever have any change in my health, I will inform the doctor at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or legal guardian

Financial Agreement

It is our policy to bill your insurance carrier as a courtesy to you. You are ultimately responsible for your account. If your insurance does not remit payment within **60 days** the balance will be due from you immediately. Returned checks are subject to a $35 NSF fee.

Please realize that:

1. Your insurance is a contract between you and your insurance carrier.
2. Our fees are comparable to other dentists in the area. This has no relationship to what insurance companies remit for payment.
3. Not all services / procedures are covered benefits by insurance companies.

We encourage all patients to read their policies and if they do not understand please speak to your employer or insurance carriers. A written treatment plan will be given prior to any services performed, but again it is only an estimate. Your dental provider will notify you during the course of your treatment if anything changes. All estimates are based on preliminary information your insurance provider has given to us.
We must emphasize that as a dental provider, our relationship is with you not your insurance company.

Signature:_____ Date:_____

Appointment Agreement

Your appointment is a commitment of time between you and our office. If you find that you cannot keep your appointment, we require a minimum of 24 hours notice so that we are able to assist other patients with their dental needs. If this notice is not given, a charge of $50 will be applied to your account. After 2 consecutive "no shows", any additional appointments you may have will be cancelled. By signing below, you understand our appointment cancelation policy, and will make every attempt to give us proper notification.

Any appointments that are more than 1 hour will require a $75 per hour non-refundable deposit to secure your appointment time.

Signature:_____ Date:_____

Dental Insurance Information

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
(Last / First / MI)

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
(Street / City / State / Zip Code)

Insured's Employer Name: _____

Address: _____
(Street / City / State / Zip Code)

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Use and Disclosure of Health Information

By signing this consent, you consent to our use and disclosure of your protected health information. This is used to carry out treatment, payment activities and healthcare operations. Understand that your health information may be accessed by our personnel during your care at this office. This practice is committed to protecting your privacy. We will only use your information as is necessary to properly diagnose and treat. By signing below, you acknowledge that we are allowed to communicate to other health care providers that we refer you to, pharmacists, and insurance providers in regards to your care.

My medical/accounting information may also be discussed with:_____

Signature_____ Date:_____

I grant permission to Stuart Prosthetic Dentistry to telephone me at home or at my work to discuss matters related to this form.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Photo Release

I, _____ authorize Stuart Prosthetic Dentistry to take confidential photos and other diagnostic images before, during, and after treatment to allow improved communication about proposed and ongoing treatment. If a request is made to use these photos for advertising/digital marketing purposes, Stuart Prosthetic Dentistry will inform me via an additional consent form at that time.