Patient Name_____ **date of birth**_____ **male** **female**

Street_____ **City**_____ **State**_____ **Zip** _____

Home Phone ( ) _____ **Work Phone** ( ) _____ **Other Phone** ( ) _____

Social Security Number_____ **Employer** _____ **Position** _____

Dental Insurance Company _____ **(please provide insurance card for photocopying)**
(fill out below if different from above)

Insured's Name _____ **date of birth**_____ **male** **female**

Street_____ **City**_____ **State**_____ **Zip** _____

Home Phone ( ) _____ **Work Phone** ( ) _____ **Other Phone** ( ) _____

Social Security Number_____ **Employer** _____ **Position** _____

WHEN BRINGING IN A MINOR-THE PERSON BRINGING IN THE MINOR IS RESPONSIBLE FOR THE CHARGES NOT PAID BY INSURANCE- WE DO NOT GET INVOLVED WITH PARENT SEPERATION/DIVORCE AGREEMENTS. *(fill out below if different from above)*

Name of accompanying adult_____ **date of birth**_____ **male** **female**

Street_____ **City**_____ **State**_____ **Zip** _____

Home Phone ( ) _____ **Work Phone** ( ) _____ **Other Phone** ( ) _____

Social Security Number_____ **Employer** _____ **Position** _____

EMG. CONTACT PERSON name_____ **address**_____ **phone**_____

Are you under the care of a physician ? (Dr. _____ type_____) yes no
Have you been hospitalized in the past 2 years ? (date/reason_____) yes no
Have you had a serious injury to your head or neck?(specify_____) yes no
Are you taking any medications/pills/drug ? (list them_____) yes no
Are you on a special diet ? (discuss_____) yes no
Women: Are you __pregnant __possibly pregnant __Nursing __taking oral contraceptives? *(check all that apply)* yes no
Are you allergic to anything? (aspirin,penicillin,codeine,metals,acylic,latex rubber) (list them_____) yes no
Do you wish to talk to the dentist privately about any problem? Yes no

Do you have or have had any of the following ? **Please circle yes or no next to each item**

Heart trouble	yes no	bruise easily	yes no	emphysema	yes no	yellow jaundice	yes no	cold sores	yes no
Heart murmur	yes no	anemia	yes no	tuberculosis	yes no	kidney problems	yes no	fever blisters	yes no
Irregular heart beat	yes no	excessive bleeding	yes no	cancer	yes no	renal dialysis	yes no	herpes	yes no
Angina/chest pain	yes no	sickle cell disease	yes no	radiation/x-ray treatment	yes no	thyroid disease	yes no	stroke	yes no
Heart attack/failure	yes no	hemophilia/bleeding	yes no	chemotherapy	yes no	parathyroid disease	yes no	convulsions	yes no
Congenital heart disorder	yes no	leukemia	yes no	stomach/intestinal disease	yes no	arthritis/gout	yes no	epilepsy/seizures	yes no
Mitral valve prolapse	yes no	recent blood transfusion	yes no	ulcers	yes no	rheumatism	yes no	fainting/dizziness	yes no
Scarlet fever	yes no	swelling of limbs	yes no	recent weight loss	yes no	pain in jaw joints	yes no	glaucoma	yes no
Rheumatic fever	yes no	lung disease	yes no	frequent diarrhea	yes no	cortisone medicine	yes no	tumors/growths	yes no
Artificial heart valve	yes no	breathing problems	yes no	diabetes	yes no	artificial joint	yes no	nervousness	yes no
Heart pacemaker	yes no	shortness of breath	yes no	excessive thirst	yes no	venereal disease	yes no	psychiatric care	yes no
Heart surgery	yes no	frequent cough	yes no	hypoglycemia	yes no	AIDS	yes no	Alzheimer's disease	yes no
High blood pressure	yes no	hay fever	yes no	liver disease	yes no	HIV positive	yes no	allergies(Medicines)	yes no
Low blood pressure	yes no	sinus trouble	yes no	hepatitis A(infectious)	yes no	genital herpes	yes no	allergies (pollen/dust)	yes no
Blood disease	yes no	asthma	yes no	hepatitis B or C	yes no	drug addiction	yes no	hives or rash	yes no

Have you ever had any other serious illness not listed above ? Discuss_____ yes no

Do you have a specific dental problem ? Describe_____ yes no
When was your last dental visit and what was it for ?_____
Who was your former dentist? _____ reason for leaving_____

Due to previous injuries, we respectfully request that **only** the patient be in the treatment room. Please **no children in the treatment area unless** they are the patient. We request that only 1 parent accompany children- but **visits always go better when children are not being observed by parents.** Adults or minors with **mental or physical handicaps** may be assisted by parents/guardians or caretakers.

To the best of my knowledge all my answers are correct. I consent to all treatment as explained. I have read and agree to all the policies and agree to abide by them. All patient financial responsibility will be discussed prior to treatment. All unpaid balances will be the responsibility of the patient or guardian/parent if a minor (under 18 years of age).

Patient/guardian _____ Dr. _____ date_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please read carefully

Uses and Disclosure of Health Information

Treatment, Payment, and Healthcare Operation

Stewart Dental Care uses and discloses your protected health information for treatment and payment and healthcare operations. It is the general policy of Stewart Dental Care that protected health information will be used and disclosed only in accordance with the Health Insurance Portability and Accountability Act of 1996. Some examples of when our office may use your health care information for these purposes include

- Sharing test results with other healthcare providers for confirmation of diagnosis
- Providing diagnosis or other information about your health with your insurance provider or out billing service to obtain payment for healthcare services we provide
- Reviewing information as part of our quality assurance program

Other Uses and Disclosures

Stewart Dental Care may also disclose your protected health information in compliance with guidelines for the following purposes

- Providing you with information related to your health
- Contacting you regarding appointments, information about treatment alternatives, or other health related services
- Incidental uses or disclosures (daily appointment sheets)
- Compliance with the law including suspected abuse, neglect, or violence
- Providing certain specified information to law enforcement or medical examiner
- Providing information to workers compensation for work related injury
- Public Health Activities as requested by the FDA
- Responding to court orders
- When necessary to overt a serious threat to health or safety
- Providing information to military or veterans affairs
- Informing a family member, other relative, or close personal friend when:
  Information is relevant to the individual's involvement with your care
  Notification of your location or general condition
  To assist in your health care (ie picking up prescriptions or other documents, follow up care)

Authorization for Other Uses

Stewart Dental Care will obtain your signature for any other uses.

Your Rights Regarding the Privacy of Your Health Information

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information including the right to:

- Requesting restrictions on certain uses and disclosures. However SDC is not obligated to agree to the request
- Receive confidential communications of protected health information
- Inspect and copy your protected health information with some exceptions
- Amend your health information
- Receive an accounting of disclosures
- Obtain a copy of this notice

I acknowledge that I have received a copy of this notice regarding the uses and disclosure of my health information

_____ _____

Signature of patient or representative date relationship to patient if other than patient

Financial Policy

Do you have Insurance?

If you have insurance, let us first clear up some common misconceptions. **Most traditional insurance plans are not designed to pay 100% of your dental costs.** Rather they are intended to pay a percentage or a fixed amount toward the cost of a specified dental procedure. In addition most plans have individual and/or family deductibles that must be paid by you before benefits begin paying. Your specific benefits are negotiated between your employer and the insurance company. We do not participate in these negotiations-so if your benefits are poor and did not pay or paid little toward your care-please direct your anger toward your employer and the company-not our staff. **Our only role with insurance is assisting you by filing the claim for you free of charge.**

How and when do I pay for treatment?

We accept MasterCard, Visa, Amex, Discover. We also accept cash and personal checks. We also offer financing with a 3rd party lender called "Enhance" or the "Medical Bureau" for those who qualify. Enhance works similar to a credit card but offers a few interest free options for those who qualify.

Payment is due at the time of service for all known co-payments. Patients with traditional insurance whose benefits are uncertain must pay any unpaid insurance balances immediately after insurance settlements. **Our practice does not have the resources or expertise to function both as a dental provider and lender**, and therefore we do not finance dental treatment costs.

Do we send Bills?

We have eliminated all unnecessary billing. **All known co-payments and patient balance must be paid at the time of visit.**

What if I don't pay?

A **$5.00 statement processing fee will be imposed** for each past due statement sent. In addition a finance charge of **1.5% per month will be added to any balance 30 days old.** After 3 billing statements your account will be turned to the **CREDIT BUREAU** for further action and you will be responsible for any collection charges incurred.

If your check bounces?

A $25.00 charge will be added

What if I just don't show up for an appointment?

Your reserved time has value and we require **24 hour notice** for cancellations so that someone else may receive treatment in your place. Without this notice treatment time is wasted which could have been assigned to someone else. We may charge up to **$20.00 for missed appointments** or "last minute cancellations". 3 missed appointments without a courtesy call 24 hours before your appointment will result in the doctor/patients relationship being terminated and you will need to find another dentist.

Thank you for your understanding of our policies. If you have any questions or concerns about our policies please ask anyone on our staff.

I have read, understand, and agree to this financial policy.

_____(patient/guardian)_____(date)