



PATIENT INFORMATION

Date: _____ NEW PATIENT UPDATE

Patient: _____

LAST FIRST MI PREFERRED TITLE

MALE FEMALE CHILD* STUDENT** SINGLE MARRIED DIVORCED WIDOWED

*IF CHILD, PROVIDE PARENT/GUARDIAN NAME(S) BELOW: _____

PARENT/GUARDIAN NAME(S)

**IF STUDENT, PLEASE COMPLETE: FULL-TIME PART-TIME

SCHOOL/LOCATION _____

Patient Date of Birth: _____ Patient SSN: _____

Address: _____

ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY ST ZIP CODE

E-Mail: _____

HOME: _____

CELL: _____

OTHER: _____

PAGER: _____

FAX: _____

Referral? Yes No Referred by: _____

EMERGENCY INFORMATION

In case of emergency, please provide information for the nearest relative or designated contact person not at the patient's address:

NAME RELATIONSHIP Tel: _____

RESPONSIBLE PARTY

Name: _____ Occupation: _____

Address: _____

ADDRESS LINE 1 _____

ADDRESS LINE 2 _____

CITY ST ZIP CODE

E-Mail: _____

WORK: _____ X

CELL _____

HOME: _____

DOB: _____

SSN: _____

INSURANCE INFORMATION

Subscriber: _____

LAST FIRST MI PREFERRED TITLE

Subscriber Date of Birth: _____ Subscriber SSN: _____

Subscriber Employer: _____

Patient Relationship to Subscriber: SELF SPOUSE CHILD OTHER

PRIMARY INSURANCE CARRIER:

Group/Policy No.: _____ ID No.: _____

Address: _____

CITY ST ZIP CODE

TEL: _____

TOLL-FREE: _____

FAX: _____

SECONDARY INSURANCE

CARRIER(ONLY DELTA DENTAL):

Group/Policy No.: _____ ID No.: _____

Address: _____

CITY ST ZIP CODE

TEL: _____

TOLL-FREE: _____

FAX: _____

PREVIOUS DENTIST INFORMATION

Dentist: _____ Telephone: _____
 Clinic/Facility: _____
 Address: _____

 CITY ST ZIP CODE
 Reason for changing: _____

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR
 Date of Last Dental Visit: _____ Treatment Type: _____

Blood Pressure:

Y N Are you currently having dental discomfort? If yes, explain: _____
 Y N Any unhappy/unpleasant dental experiences? If yes, explain: _____
 Y N Any injuries to mouth/teeth/head? If yes, explain: _____
 Y N Any missing teeth other than wisdom teeth or orthodontic extractions?
 Y N Have missing teeth been replaced?
 Y N Orthodontic appliances now or in the past?
 Y N Gums bleed when brushing or flossing?
 Y N Concerned about gum disease? History of gum disease? Y N
 Y N Any concerns about the appearance of your teeth?
 Y N Does it hurt to bite or chew?
 Y N Do you clench or grind your teeth? If so, do you wear a night guard or splint? Y N
 Y N Do you want to become a regular continuing care patient in our practice?
 Y N Do you want your mouth properly restored and pain free?
 Y N Does any type of dental treatment make you nervous? If yes, please explain below:

The most important concerns regarding my dental treatment are:

What factors are most important for your satisfaction with our office?

Any additional concerns/comments?

CHILD/MINOR PATIENTS: PLEASE ANSWER THE FOLLOWING QUESTIONS:

Y N Any mouth habits? (thumb sucking, nail biting, mouth breathing, nursing/bottle habits, pacifier, etc.)
 Y N Any unusual speech habits? If yes, explain: _____
 Y N Any lost teeth? If yes, list: _____
 Y N Does the patient receive assistance with brushing and flossing? If yes, how often?

PRIMARY PHYSICIAN INFORMATION

Physician: _____ Telephone: _____
 Clinic/Facility: _____

Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

- **We are in network for Delta Dental Premier**
- **No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

Payments

- **Patient portion or patient co-pay is due at the time services are rendered** - unless prior financial arrangements have been made.
- **Payment Information:**
 - o All major credit cards are accepted (Visa, MasterCard, Discover)
 - o Various financing options with CareCredit®
- **Balances left over 90 days will incur 21%** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 24 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short Cancelled/Missed appointments will be charged \$40. Fee must be paid within 30days. All appointments will be suspended until fee is paid**

By signing below I acknowledge I have read and understand the guidelines above.

Signature:

Date:

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Updated 2013

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature:

Date:

RELATIONSHIP TO PATIENT: ADULT PATIENT PARENT GUARDIAN OTHER

Please list any dependent children under the age of 18 also covered by this acknowledgement:

I give permission for the following communications to be used by Dr. C Dawn Strohschein DDS, (please check all that apply) :

- Cell phone: Text Message reminders permitted
- Home phone Work E-Mail:

I am granting permission for Dr. C Dawn Strohschein DDS to disclose their identity to anyone who may answer my home, work or cell phone.

I am granting permission for Dr. C Dawn Strohschein DDS to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

- Home Phone Cell Phone Work Phone None- please just ask for a call back
- Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children listed above:

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other – please list:

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or if my medication changes, I shall inform the dentist and staff at the next appointment without fail.

I hereby authorize payment directly to Dr. Strohschein of the dental benefits otherwise payable to me.

I hereby authorize Dr. Strohschein to release any information concerning my health or dental care, advice, treatment or supplies provided. This information is to be used in administering dental claims and/or discussing treatment options with other dental professionals.

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered.

By signing below, I acknowledge that I have read and understand the statements mentioned above.

Signature:

Date: