Stanfield Dental PLLC, DBA Glendale Gentle Dentistry, PC

Health History

Name- _______________ ❑Male ❑Female

First Middle Last Date of Birth

- Reason for today's visit? _____
- When was your last visit to a dentist? What was it for? _____
- Are you having pain or discomfort at this time? …….. ❑Yes ❑No
- Do you feel very nervous about having dental treatment? …… ❑Yes ❑No
- Have you ever had a bad experience in a dental office? ……... ❑Yes ❑No
- Have you been under the care of a physician during the last two years? ..... ❑Yes ❑No
  Physician's name____ _____
  Address_____
  Phone Number_____
- Are you now taking any medications, drug, pills or use tobacco? ..... Yes No
  If yes, please list_____
- Are you allergic to or have you reacted adversely to any medications or substances?
- ❑Yes ❑No Aspirin ❑Yes ❑No Codeine ❑Yes ❑No Other
  ❑Yes ❑No Penicillin ❑Yes ❑No Erythromycin if yes, please list_____
  ❑Yes ❑No Local Anesthetic ❑Yes ❑No Latex
- Have you ever been a patient in a hospital? ..... Yes No
  Please list procedures performed _____
  PREMED is the patients responsibility. Pharmacy info _____
- Have you in the past or do you currently have:
  ❑Yes ❑No Heart Disease/Attack ❑Yes ❑No Epilepsy or Seizures ❑Yes ❑No TMJ Treatment
  ❑Yes ❑No High Blood pressure ❑Yes ❑No Hemophilia ❑Yes ❑No Diabetes
  ❑Yes ❑No Heart Murmur ❑Yes ❑No Artificial Joints ❑Yes ❑No Psychiatric Treatment
  ❑Yes ❑No Rheumatic fever ❑Yes ❑No Venereal Disease ❑Yes ❑No HIV+
  ❑Yes ❑No Heart Surgery ❑Yes ❑No Kidney Disease ❑Yes ❑No Hepatitis B (serum)
  ❑Yes ❑No Mitral Valve Prolapse ❑Yes ❑No Pain in Jaw Joints ❑Yes ❑No Drug addiction.
- Do you have any disease, condition or problem that is not listed? …….. ❑Yes ❑No
  If yes, please describe_____
- For Women Only:
  Are you taking Birth Control Pills? ..... ❑Yes ❑No
  Are you pregnant? .....❑Yes ❑No
  If yes, what month? _____

Consent: To the best of my knowledge, the above information on this Health History sheet is as complete and accurate as possible. I understand that without full and accurate information the doctor may not be able to provide me with the best care possible. I hereby authorize the Doctor to take radiographs (X-rays), study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to perform any and forms of treatment, medication & therapy, which may be indicated and I further authorize and consent that the Doctor choose and use such assistance as he/she deems fit.

Signature of Patient (or Responsible Party) _____ Date_____

Health History Reviewed by Provider _____Date_____

Stanfield Dental PLLC, DBA Glendale Gentle Dentistry, PC

PATIENT INFORMATION

_____ _____ _____

NAME- First Middle Last Date of Birth Social Security Number

_____ _____ _____

ADDRESS- Street City State Zip Code Marital Status

_____ Male Female

TELEPHONE NUMBERS- Cell _____ Alt Contact/ Emergency #_____

E-Mail: _____

RESPONSIBLE PARTY INFORMATION- (If **patient is not the responsible party)**

_____ _____ _____

NAME- First Middle Last Date of Birth Social Security Number

_____ _____

ADDRESS- Street City State Zip Code Relationship to Patient

_____ Male Female

TELEPHONE NUMBERS- Home Work or School Cellular

INSURANCE INFORMATION we will bill as a courtesy.

Insurance knowledge is the responsibility of the insured.

_____ _____ _____

NAME- First Middle Last Date of Birth Social Security Number

_____ _____

ADDRESS- Street City State Zip Code Relationship to Patient

_____ Male Female

TELEPHONE NUMBERS- Home Work or School Cellular

_____ _____

INSURANCE COMPANY- Name Address Insurance id Telephone Number

_____ _____

EMPLOYER- Name Address Telephone Number

Stanfield Dental PLLC, DBA Glendale Gentle Dentistry, PC

Financial & Other Policies

Thank you for choosing us as your dental health care provider. We are committed to your treatment being successful. Please understand that payment for services rendered is part of your treatment. The following is a statement of **Stanfield Dental PLLC, DBA Glendale Gentle Dentistry, PC**

Financial & Other Policies which need to be read and signed before seeing the doctor/& or beginning any treatment.

Payment- Payment of all of patient's estimated co-payments &/or deductibles are due at check in prior to services being rendered. Payment may be made with cash, check, Visa/MC, Discover, American Express, debit card or by 3rd party financing.

Dental Insurance/Plan- We work with most dental insurance/plan. We will attempt to help you determine what your dental insurance plan benefits are, based on the information that you and the company provide to us. Your dental insurance plan policy is a contract between you and your dental insurance plan. We are not party to that contract, and therefore cannot accept any responsibility for the accuracy of the discounted fees, co-payments, deductibles or other dental insurance plan benefits. If you require a binding fee estimate or predetermination of benefits prior to treatment it must come from your dental insurance plan. Our Estimates are ESTIMATES only the patient is responsible for the entire billed amount. Payments received from insurance will only reduce the estimated patient responsibility for services rendered.

As mentioned above, all estimated co-payments &/or deductibles are required to be paid prior to service. Any remaining balance is your responsibility whether the dental insurance plan covers and pays for the service or not. We are only able to successfully bill the dental insurance plan on your behalf if given complete and accurate insurance information and an original claim form.

***ANY TREATMENT PLANS FEES PRESENTED ARE **ESTIMATES** TO OUR BEST ABILITIES OF WHAT YOUR INSURANCE CARRIER WILL PAY. Ultimately you are responsible for any balances not paid by the insurance. ***

You authorize us to release any & all information necessary to secure payment of benefits and to use your signature below on all dental insurance plan submissions.

If your dental insurance plan has not paid your account in full within 60 days of rendering services, you hereby agree that you are required to immediately pay the complete remaining balance. Any payment received by us by the dental insurance plan after this time will be forwarded to you. In the event that your dental insurance plan coverage changes or does not cover your treatment, you will be billed our usual and customary fees for the services rendered.

Usual and Customary Fees- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for your area. You are responsible for this payment regardless of any dental insurance plan arbitrary determination of usual and customary fees.

Past Due Balances- A 1.5 % billing charge per month (18% annually, $1.50/month minimum) will be added to any balance after completion of planned treatment. In the event of default, you promise to pay balance, any legal interest on the indebtedness, together with such reasonable collection costs and attorney fees as may be required to collect the entire balance.

Returned Checks- There is a fee of $50 for any checks returned by the bank.

Missed Appointments-Unless appointments are cancelled or rescheduled at least 48 hours in advance, our policy is $ 50 PER HOUR and to dismiss patients that miss two appointments from the practice. Mon & Tues but be resched the THUR prior by noon. We also charge a fee of $75.00 PER HOUR for any appointment cancelled or rescheduled without a 24 hour notice. Please help us serve you and all our patients better by keeping scheduled appointments. Voicemails and Texts are not acceptable means of cancellation and rescheduling.

I certify that I have dental insurance plan coverage as indicated and assign directly to **Stanfield Dental PLLC, DBA Glendale Gentle Dentistry, PC**

all insurance benefits otherwise payable to me for services rendered. I have read the Financial & Other Policies. I understand and agree to the terms of the Financial & Other Policies.

_____ _____

Signature of Patient (or responsible Party) **Date**