John R. Striebel Dentistry

Patient Information

Date_____

Patient's Name _____

Last First Middle

Patient's Address_____

Cell _____ Home _____ Work_____ Email _____

Birthdate _____ Social Security _____ Martial Status_____

Employer name & Address _____

Occupation_____ Employer Phone _____

Spouse's Name_____

Last First Middle

Birthdate _____ Social Security _____ Spouse's Phone Number_____

Employer name & Address _____

Occupation_____Employer Phone _____

Who is responsible for this account? _____

May we contact you thru:

- ○ Email
- ○ Text message
- ○ Calls to cell
- ○ Calls to home
- ○ Calls to work
- ○ Call/text Spouse

Whom may we thank for referring you? _____

Insurance Information

Insurance Company_____ Member's ID or Subscriber SSN _____

Subscriber's name_____ Subscriber's Date of Birth_____

Subscriber's Address _____

Secondary Insurance

Insurance Company_____ Member's ID or Subscriber SSN _____

Subscriber's name_____ Subscriber's Date of Birth_____

Subscriber's address_____

Medical History

Physician's name: _____ Date of last visit: _____

Have you had any of the following:

- o Anemia
- o Alzheimer's disease
- o AIDS, HIV
- o Artificial heart valves
- o Artificial joints
- o Asthma
- o Angina
- o Back problems
- o Bleeding abnormally after extractions or surgery
- o Blood disease
- o Cancer
- o Chemical dependency
- o Chemotherapy
- o Chest pain upon exertion
- o Circulatory problems
- o Congenital heart defects
- o Cortisone treatments
- o Persistent or bloody cough
- o Diabetes
- o Epilepsy, convulsions
- o Fainting or dizziness
- o Headaches, migraines
- o Heart murmur
- o Heart valve problems
- o Heart attack
- o Hepatitis, type: _____
- o Herpes
- o High blood pressure
- o Hypoglycemia
- o Jaundice
- o Joint replacement
- o Kidney disease
- o Liver disease
- o Low blood pressure
- o Mitral valves prolapse
- o Neurological problems
- o Pacemaker
- o Psychiatric care
- o Radiation treatment
- o Respiratory disease
- o Rheumatic fever
- o Sleep disorder
- o Shortness of breath
- o Sinus trouble
- o Stroke
- o Substance abuse
- o Swollen neck glands
- o Thyroid problems
- o Tuberculosis
- o Tumor or growth on head or neck
- o Reflux, heartburn
- o Venereal disease
- o Hospitalized in last 2 years
- o Illness or impending medical treatment that may affect your dental treatment_____
  _____
  _____
  _____

Women:

- o Pregnant, due date
  _____
- o Nursing
- o Taking birth control pills

Please list the medications you are currently taking: _____

_____

Pharmacy name: _____ Phone: _____

Allergies:

- o Aspirin
- o Motrin
- o Codeine
- o Latex
- o Local anesthetic
- o Penicillin
- o Sulfa
- o Metal
- o Other: _____
  _____
  _____
  _____

My medical history is accurate and complete. I understand it is my responsibility to inform the dental office of any changes in my medical status. I give permission for my dentist and clinical team to take any necessary x-rays, photos, and study models to make s complete diagnosis of my dental needs. I consent to use my dental information to obtain insurance payment.

_____

Parent or Guardian's Signature Today's date

In case of emergency please contact:

Name: _____ Relationship to you: _____

Address: _____ Phone: _____

Dental History

Reason for today's visit _____

Date of last dental visit _____ Date of last dental x-rays_____

Do you have any of the following:

- ○ Teeth sensitive to cold, heat or sweets
- ○ Teeth sensitive when chewing
- ○ Bleeding or swollen gums
- ○ Loose teeth
- ○ Food collecting between teeth
- ○ Broken fillings
- ○ Grinding or clenching teeth
- ○ Clicking or popping of the jaw
- ○ Jaw tiredness
- ○ Pain around your ear
- ○ Burning of the tongue
- ○ Sores or swellings in your mouth
- ○ Bad breath
- ○ Complication from extractions
- ○ Problems during previous dental work
- ○ Cigarettes, pipe, or cigar smoking
- ○ Chewing tobacco
- ○ Dry mouth
- ○ Blisters on lips or mouth
- ○ Lip or cheek biting

Do you like your smile? _____

How often do you brush? _____

How often do you floss? _____

Financial Policy

Our office offers the following payment options so that our patients can choose which option best suits their needs:

Dental Insurance: Our office will gladly work with you to help you get the maximum benefit available to you. Most dental insurance plans do not cover 100% of your cost of treatment. Therefore, you will be asked to ***pay your deductible and your co-payment for the charges on the day the service is rendered***. We will gladly estimate your coverage; however, many variables exist from carrier to carrier. With your insurance being an agreement between you and the insurance company, you are responsible for all charges.

If your insurance company has not paid their portion within 60 days from the start of your treatment, you are responsible for payment at that time.

Payment Options: Patients are responsible for their charges at the time the service is provided. We accept all major credit/debit cards (Visa, Master Card, Discover, Amex) cash and checks.
Care Credit: We are happy to offer our patients, upon application approval, a monthly payment plan through Care Credit. Our staff will gladly assist you in the application process. There are several interest-free payment plans to choose from and some extended payment plans with small interest rates offered as well. Please feel free to request more information about this option.
Implants and Surgeries: Pre-payment basis only and must be paid in full the day before the surgery.

I understand I am responsible for my account regardless of my insurance. I understand that my insurance is an agreement between me and my insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize release of information to secure payment of benefits. I authorize the use of this signature on all insurance claims.

For any returned check, a $30.00 charge will be added to the account.

If your balance becomes 30 days or more overdue, our office reserves the right to refuse appointments and send your account to collections. In the event your account is sent to collections, you will be responsible for all costs and fees, including attorney fees.

Our front office staff is available to answer any of your concerns and questions regarding billing, insurance coverage and cost of service over the phone and in person during regular business hours.

_____

Signature of patient Date

_____

Signature of parent/guardian (if a minor) Date

HIPAA Compliance

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing t any time and all full disclosure will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email or text you to confirm appointments?	Yes	No
May we leave a voicemail on your home phone and/or cell phone?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If yes, please name the members allowed: _____

_____

_____

Signature of patient Date

_____

Signature of parent/guardian (if a minor) Date

Appointment Scheduling & Missed Appointment Policy

Appointments Scheduling

Appointments can be scheduled through our website, by text and over the phone at your convenience. As a courtesy, we are available to schedule your next appointment, reschedule your appointment and provide appointment reminders.

Please call our office to reschedule your appointment as soon as you know there is a conflict. We are ***available business days only****, Monday through Friday for rescheduling and receiving a cancelation notice*. Any missed appointments within ***48-hours*** to your appointment are subject to this policy.

Appointments to be rescheduled or canceled ***on a Monday, must be called by the prior Thursday*** before the appointment time to avoid a fee. Appointments to be rescheduled or canceled ***on a Tuesday, must be called by the prior Friday before noon*** to avoid a fee. Our business hours are provided below as a reminder.

Monday through Thursday (8am – 5pm)
Friday (8am -12pm)

Missed Appointments

To provide the most available care to our patients, any appointment that has a no show or late cancelation will be assessed a fee and charged to your account. The type of missed appointment causes different conflicts for the office, due to this the missed appointment fees will differ depending on service.

Late-cancelation: Cancelation within the ***48-hours*** to the appointment.
The first and second ***late cancelation will be charged a $50 fee.***
Any surgical procedures are evaluated by a case-by-case basis.

No-show: No cancelation notice was provided.
The first and second ***no-show will be charged a $50 fee.***
Any surgical procedures are evaluated by a case-by-case basis.

The third missed appointment could result in termination of the dentist /patient relationship.
Any questions you may have regarding this policy please ask our staff.

Please sign and date below your acknowledgement. I have read and understand the appointment scheduling process, the courtesies that are available to me and protocol for missed appointments. I understand and accept that a fee will be charged to my account for missed appointments. I understand that the third missed appointment will result in termination as a patient. I agree to the Appointment Scheduling & Missed Appointment Policy.

_____

Signature of patient Date

_____

Signature of parent/guardian (if minor) Date