STETSON VILLAGE FAMILY DENTISTRY

WELCOME TO OUR OFFICE!

Stetson Village Family Dentistry proudly serves several communities in the north central valley and surrounding areas. We provide exceptional general dentistry for your entire family, including cosmetic and implant dentistry.

Our mission is to help you achieve your best smile by not only having some pretty amazing hygienists to keep your teeth healthy and clean but also provide you with options to perfect your smile with cosmetic dentistry like Invisalign, take-home and same-day whitening, and single visit CEREC crowns.

Our friendly and competent staff are experts in providing comfort and quality care. With a gentle, family-oriented approach, we use the latest and greatest in dental technology and treatment options, as well as the most advanced equipment sterilization available process. We offer care that is comfortable and convenient for you and your entire family.

We look forward to welcoming you to our dental family!
Please fill out the following new patient forms to the best of your ability. You can download them to your computer, fill them out with any PDF reader and then email them to us.

If you wish to bypass filling these out at home or work, you are free to use the convenient **kiosk** in our lobby which will allow you to fill out your forms quickly without having to print or email. *Just ask the front desk when you arrive for your first visit.

PATIENT REGISTRATION

ID: _____ Chart ID: _____

STETSON VILLAGE FAMILY DENTISTRY

First Name: _____ Last Name: _____ Middle Initial: ____

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State, Zip _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date: _____ Age: _____ Soc Sec: _____ Drivers Lic: _____

E-mail: _____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part-time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Referred By: _____

Previous Dentist: _____

Emergency Contact: _____

Emergency Contact #: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____

Address: _____

Address 2: _____

City, State, Zip: _____

Rem. Benefits: _____.00 Rem. Deduct: _____.00

Ins. Company: _____

Address: _____

Address 2: _____

City, State, Zip: _____

MEDICAL HISTORY

STETSON VILLAGE FAMILY DENTISTRY

PATIENT NAME: _____ BIRTH DATE: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	◯ Yes	◯ No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	◯ Yes	◯ No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	◯ Yes	◯ No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	◯ Yes	◯ No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes	◯ No	_____
Have you ever taken Fosamax, Bon iva, Actonel or any other medications containing bisphosphonates?	◯ Yes	◯ No	_____
Are you on a special diet?	◯ Yes	◯ No	
Do you use tobacco?	◯ Yes	◯ No	
Do you use controlled substances?	◯ Yes	◯ No	

Women: Are you

Pregnant / Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs

☐ Other If yes, please explain _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes	◯ No	Cortisone Medicine	◯ Yes	◯ No	Hemophilia	◯ Yes	◯ No	Radiation Treatments	◯ Yes	◯ No
Alzheimer's Disease	◯ Yes	◯ No	Diabetes	◯ Yes	◯ No	Hepatitis A	◯ Yes	◯ No	Recent Weight Loss	◯ Yes	◯ No
Anaphylaxis	◯ Yes	◯ No	Drug Addiction	◯ Yes	◯ No	Hepatitis B or C	◯ Yes	◯ No	Renal Dialysis	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	Easily Winded	◯ Yes	◯ No	Herpes	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Angina	◯ Yes	◯ No	Emphysema	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No	Rheumatism	◯ Yes	◯ No
Arthritis/Gout	◯ Yes	◯ No	Epilepsy or Seizures	◯ Yes	◯ No	High Cholesterol	◯ Yes	◯ No	Scarlet Fever	◯ Yes	◯ No
Artificial Heart Valve	◯ Yes	◯ No	Excessive Bleeding	◯ Yes	◯ No	Hives or Rash	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Artificial Joint	◯ Yes	◯ No	Excessive Thirst	◯ Yes	◯ No	Hypoglycemia	◯ Yes	◯ No	Sickle Cell Disease	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Fainting Spells/Dizziness	◯ Yes	◯ No	Irregular Heartbeat	◯ Yes	◯ No	Sinus Trouble	◯ Yes	◯ No
Blood Disease	◯ Yes	◯ No	Frequent Cough	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No	Spina Bifida	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Frequent Diarrhea	◯ Yes	◯ No	Leukemia	◯ Yes	◯ No	Stomach/Intestinal Disease	◯ Yes	◯ No
Breathing Problem	◯ Yes	◯ No	Frequent Headaches	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Bruise Easily	◯ Yes	◯ No	Genital Herpes	◯ Yes	◯ No	Blood Pressure	◯ Yes	◯ No	Swelling of Limbs	◯ Yes	◯ No
Cancer	◯ Yes	◯ No	Glaucoma	◯ Yes	◯ No	Lung Disease	◯ Yes	◯ No	Thyroid Disease	◯ Yes	◯ No
Chemotherapy	◯ Yes	◯ No	Hay Fever	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No	Tonsillitis	◯ Yes	◯ No
Chest Pains	◯ Yes	◯ No	Heart Attack/Failure	◯ Yes	◯ No	Osteoporosis	◯ Yes	◯ No	Tuberculosis	◯ Yes	◯ No
Cold Sores/Fever Blisters	◯ Yes	◯ No	Heart Murmur	◯ Yes	◯ No	Pain in Jaw Joints	◯ Yes	◯ No	Tumors or Growths	◯ Yes	◯ No
Congenital Heart Disorder	◯ Yes	◯ No	Heart Pacemaker	◯ Yes	◯ No	Parathyroid Disease	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Convulsions	◯ Yes	◯ No	Heart Trouble/Disease	◯ Yes	◯ No	Psychiatric Care	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
									Yellow Jaundice	◯ Yes	◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ **DATE** _____

HIPAA CONSENT

HEALTH INSURANCE PROBABILITY AND ACCOUNTABILITY ACT

STETSON VILLAGE FAMILY DENTISTRY

I hereby give my consent for Stetson Village Family Dentistry to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO) as outlined in the Notice of Privacy Practices. The Notice of Privacy Practices describes such uses and disclosures more completely and is available for review upon request.

Stetson Village Family Dentistry reserves the right to update its Notice of Privacy Practices as needed. Patients may request a copy of the most current notice by contacting our Peoria office directly.

With this consent, Stetson Village Family Dentistry may call my home or alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, patient statements or letters.

With this consent, Stetson Village Family Dentistry may email my home or alternative location any items that assist in carrying out TPO such as appointment, reminders and statements. I have the right to request Stetson Village Family Dentistry restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Stetson Village Family Dentistry to use and disclose my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Stetson Village Family Dentistry may decline treatment to me.

Signature of Patient/Legal Guardian	Print Name	Date

FINANCIAL POLICY

STETSON VILLAGE FAMILY DENTISTRY

At Stetson Village Family Dentistry we strive to deliver the finest quality dental care possible. In addition, we are also dedicated to making this top quality care as cost-effective as possible. We will always inform you of what the fee for your treatment will be prior to initiation.

Payment Options: Payment for all services is due at the time services are rendered unless an alternate payment agreement has been reached and signed by both parties. To assist you with your healthcare, we offer a variety of payment options including: cash, check, Visa, MasterCard, Discover and American Express. Extended and interest free payment plans (credit approval required) are also available.

Financial Terms:

- A $45.00 fee for appointments that are failed or canceled without 48-hours notice may be assessed.
- In order to reserve time with the doctor for treatment, a reservation fee may be required
- There will be a $25.00 charge for non-sufficient funds checks
- Any unpaid balances, including insurance over 60 days are subject to a 1.5% monthly finance charge.
- Stetson Village Family Dentistry reserves the right to charge a collection fee of 35% of the principal balance at the time of write off or dismissal to a third-party collection agency.

Signature of Patient/Legal Guardian	Print Name	Date

MEDIA RELEASE

STETSON VILLAGE FAMILY DENTISTRY

I hereby authorize Stetson Village Family Dentistry, hereafter referred to as "Company," to publish photographs taken of me on and my name and likeness, for use in the Stetson Village Family Dentistry print, online, social media and video-based marketing materials, as well as other Company publications.

I hereby release and hold harmless Stetson Village Family Dentistry from any reasonable expectation of privacy or confidentiality associated with the images specified above.

I further acknowledge that my participation is voluntary and that I will not receive financial compensation of any type associated with the taking or publication of these photographs or participation in company marketing materials or other Company publications. I acknowledge and agree that
publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Stetson Village Family Dentistry, its contractors, its employees, and any third parties involved in the creation or publication of marketing materials, from liability for any claims by me or any third party in connection with my participation.

Authorization

Printed Name: _____

Signature: _____ **Date:** _____

Parent or legal Guardian name: _____

Signature: _____ **Date:** _____