



STONES CROSSING DENTISTRY, INC

Name _____

We are excited to welcome you and your family to our dental practice. At any time feel free to ask questions. Our office is open Monday through Thursday. In case of a dental emergency, our phones are answered 24 hours a day. Should our voice mail system answer your emergency call, simply press one, leave a detailed message and Dr. Wilkins will be paged automatically. It is important to leave a call back number so your call may be returned.

At Stones Crossing Dentistry we want your experience to be a good one. Let us know if you have any special concerns about your dental treatment. It is no surprise to us that the dental office is not everyone's favorite place to visit. Our goal is to change that opinion.

We will be happy to file insurance for you. Any estimation given is not a guarantee of payment and is based on information supplied by your insurance company. We strive to be as accurate as possible, however your insurance benefits are your responsibility and the total fee is your balance.

We offer a wide range of dental services. Cleanings, non-surgical gum treatment, white bonded fillings, crowns, bridges, cosmetic veneers, root canals, implant retained restorations, dentures, partials, whitening, and braces to name a few. We offer such a wide range of services to our patients because we understand it takes time to become comfortable with a dental office. Therefore, unless it is in your best interest, we want you to be treated here, where you are comfortable.

We also understand that sometimes offering payment options can be helpful, and can save you time and money in the long run. We have flexible payment options that will offer you choices. Just ask if this would be helpful.

How did you hear about our office? Friend/Family (Name) _____
Newspaper Website Coupon Yellow Pages

What did you like or dislike about your last dental office?

Please rate how you feel about the appearance of your smile: Circle your answer

I like it very much I like it It's okay I would like to change it

What would you like to change about your smile?

What do you want to accomplish for today's visit?

Check any of the following that you are interested in learning about.

Whitening Straightening w/o Braces Tooth colored fillings
Custom characterized dentures/partial Implants Other _____

MEDICAL HISTORY

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 _____
- 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 Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

- Do you have, or have you had, any of the following?
- | | | | |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No | Hemophilia <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No | Diabetes <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No | Rheumatism <input type="radio"/> Yes <input type="radio"/> No |
| Anemia <input type="radio"/> Yes <input type="radio"/> No | Easily Winded <input type="radio"/> Yes <input type="radio"/> No | Herpes <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No |
| Angina <input type="radio"/> Yes <input type="radio"/> No | Emphysema <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Shingles <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No |
| Asthma <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No |
| Cancer <input type="radio"/> Yes <input type="radio"/> No | Glaucoma <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No | Hay Fever <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |
- Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____



STONES CROSSING DENTISTRY, INC.

Name _____ Date ___/___/___

Address _____

City _____ State _____ Zip code _____

Home Phone () - Work phone () - Cell () -

E-Mail Address _____

Date of birth ___/___/___ Social security # _____

Marital Status: Married Single Divorced Widowed

Emergency Contact _____

Emergency Number () - Cell Phone () -

Person responsible for the account _____

Dental Insurance Yes No Name of the insured _____

Social security # _____ and/or Carrier ID # _____

Date of Birth ___/___/___

Employer _____ Insurance company _____

Occupation _____

Telephone number of the insurance company _____

Consent for treatment:

The undersigned hereby authorizes Dr. Wilkins, or designated staff members to take necessary radiographs, study models, photographs, or any other diagnostic aids required to make a thorough diagnosis of existing conditions. I further authorize Dr. Wilkins, or designated staff members to perform any and all forms of treatment, including administering of medications and delivery of therapy that may be indicated. I understand that the use of any anesthetic agents involves certain risks. I understand the responsibility for the payment of dental services provided in this office for my dependants or myself is mine, due and payable at the time of services rendered. Insurance will be filed as a courtesy. Estimations are based on information from your insurance company. They are not a guarantee of payment. Regardless of financial arrangements the full responsibility for payment is mine. I further understand that any finance charges, refilling fees, collections charges or attorney fees may be added to any overdue balance. I also assign all insurance benefits to Dr. Wilkins. Please note that our HIPAA policy is available for your review upon request. A copy of the policy is also displayed in our reception area.

Patient Signature (Parent of Child) _____ Date ___/___/___

Stones Crossing - Dr. Aaron Wilkins

2525 State Rd 135 | greenwood IN, 46143 | 317-535-3940

Written Financial Policy

Thank you for choosing Stones Crossing - Dr. Aaron Wilkins. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, Mastercard or Discover Card

We offer a 10% courtesy accounting adjustment to patients who pay for their treatment with cash or check prior to completion of care.

- NO INTEREST¹ Payment Plans² from CareCredit

- Allow you to pay over time with NO INTEREST¹
- Convenient, low monthly payment plans² also available
- No annual fees or pre-payment penalties

Please note:

Stones Crossing - Dr. Aaron Wilkins requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For larger, more comprehensive treatment plans of \$2000 or more, a 20% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.³

A fee of \$50 is charged for patients who miss or cancel more than 2 times in a calendar year without 24-hour notice.

Stones Crossing - Dr. Aaron Wilkins charges \$25 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)

¹If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required.

²Subject to credit approval

³However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.