

Stones Crossing Dentistry

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 estimations given are not a guarantee of payment and are 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 several plans that will offer you choices. Just ask if this would be helpful.

How did you hear about us?

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?

Circle 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 \_\_\_\_\_

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 \_\_\_\_\_

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 \_\_\_/\_\_\_/\_\_\_