Stones Crossing Dentistry, inc.

We want to learn more about you, so that we can help you file your dental insurance and get you that beautiful smile that you have always wanted. Please complete the following paperwork. Thank you!

PATIENT INFORMATION:

Name: _____ Date: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone #: _____ (Cell/Hm/Work) Alt Phone #: _____(Cell/hm/Work)

Email Address: _____ (This is used for Appt reminders and special offers)

Patient Date of Birth: _____ Patients Social Security #: _____

Drivers License #: _____

Emergency Contact: _____ Phone #: _____

Responsible Party: (Complete if other than patient)

Name: _____ Relationship to Patient: _____

Address: _____ City:_____ State: _____ Zip: _____

Phone #: _____ Birthdate: _____

SS# :_____ Derivers License # :_____

INSURANCE INFORMATION: (Complete if you have dental insurance that we will be filing for you)

Primary Dental Ins.		Secondary Dental Ins.	
Subscriber Name		Subscriber Name	
Subscriber SS#		Subscriber SS#	
Birthdate		Birthdate	
Relationship	Self/spouse/child	Relationship	Self/spouse/child
Dental Insurance Co.		Dental Insurance Co.	
Employer		Employer	
ID # (if other than ss#)		ID # (if other than ss#)	
Group #		Group #	
Insurance Phone #		Insurance Phone #	

~We will need a photocopy of your drivers license and your dental insurance card~

How did you hear about our office?

[ ] Insurance Company [ ] Internet Search [ ] Online Reviews [ ] Referral, If so, whom may we thank? _____

When was your last dental visit? _____ Why did you leave your last dentist? _____

Do you have any teeth bothering you? Yes/No. If Yes, how? _____

When you look in the mirror, is there anything that you want to change about your smile? _____

Do your gums bleed while flossing? Yes/No Sensitivity to Hot/Cold? Yes/No Pain in Jaw joints? Yes/No

Difficulty opening or closing? Yes/No Clench or Grind teeth? Yes/No Frequent headaches? Yes/No

Do you snore? Yes/No

On a scale of 1-10, with 10 being the highest rating, rate your smile. _____ Rate where you would like it to be._____

Are you interested in any of the following: (Circle if interested)

Braces Invisalign Veneers Implants Whitening Same Day Crowns Removing mercury fillings Replacing missing teeth

FINANCIAL POLICY

We are happy that you have chosen our office to be your dental provider. We accept several insurance plans to help our patients with the out- of-pocket costs of your dental care

Estimated patient payment is due at the time services are provided. Stones Crossing Dentistry, inc. will loan insurance portion until the EOB is received with payment or denial. At which time, full payment is due. We accept cash, checks, credit/debit cards, and carecredit. There is a $25 charge for returned checks plus the bank fees. We offer patients without dental insurance a 10% courtesy discount for paying with cash or check. This applies to our standard office fees and does not apply with any other offers or discounts. We offer our patients an in-office discount plan for patients without any dental insurance. Ask us for more information.

Please remember that your dental insurance policy is a contract between you and your insurance company. It is your responsibility to provide our office with your dental insurance information. If your dental coverage can not be verfified then you are considered as having no insurance, and payment of our office fees will be expected at time of service. We file your insurance claims as a courtesy to you. We provide insurance estimates, however this is not a guarantee of what your insurance company will pay. We do not know what your insurance company will pay until payment is received, and total fee is your responsibility if insurance denies payment for any reason.

All accounts with a balance at 90 day will receive a $5 billing charge. Past due accounts will be turned over to a collection agency. Any fees incurred due to this, will be added to the outstanding balance. This includes late fees, collection agency fees, court fees, attorney fees, and any other applicable fees.

I authorize the assignment of benefits to be paid directly to Stones Crossing Dentistry, inc.

I authorize the release of protected health information as described in our HIPPA policy to any insurance company, specialist office, collection agency, etc. required to assist you or our office to receive payment for services rended or referral offices in providing you care.

This agreement supersedes all prior agreements signed, including any and all mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial agreements or quality of care are null and void. I hereby agree to abide by the conditions outlined herein.

_____ _____

Patient Name (Please Print) Signature of Patient, parent or guardian Date

Consent to Treat

I authorize Dr. Aaron Wilkins or staff members to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an unwanted reaction or side effects, which may include, but are not limited to bruising, hematoma, cardiac stimulation, muscle soreness, and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past.

I give Dr. Wilkins and his staff permission to send my information to offices that request such information, namely radiographs, medical, chart information etc. that pertain to my care or care of others for which I am responsible.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. I understand that treatment has the possibility to change during the appointment time. If treatment changes for me and/or any minor or other individual for which I have responsibility, Stones Crossing Dentistry, inc. will make reasonable effort to inform me of the changes. I have the option to accept or reject treatment at that time. If I am not reachable, I authorize Stones Crossing Dentistry, inc. to proceed with treatment and I take full financial accountability for that decision.

I also acknowledge that all of the preceding answers and information provided on all forms filled out are true and correct. If I ever have any change in my health or there are changes in my child's health, I will inform Stones Crossing Dentistry, inc. at the next appointment without fail. If changes are not reported, I agree that any damage incurred will be my sole responsibility, financially, and legally.

I acknowledge that I have the right to refuse treatment at any time. I understand that refusal of treatment may result in further damage, cost and discomfort for me personally or others for which I am responsible, and will hold Dr. Wilkins his staff and Stones Crossing Dentistry inc. harmless for my decisions.

Signature: _____ Date: _____

Missed Appointment Policy

Appointment times are valuable. In order to keep costs low for our patients and ensure that all patients receive care in a timely manner we enforce a missed appointment policy. Appointments cancelled without a 24-hour notice are subject to a cancellation fee of $ 41 per hour of the scheduled appointment time. I agree that I must be at each appointment as agreed when scheduled whether or not Stones Crossing Dentistry, inc. is able to reach me to confirm this appointment.

Signature _____ Date: _____

Photo Consent Form

I give permission to Dr. Aaron Wilkins and his staff to take photos as part of my dental records. The photographs taken in our office may be used for case presentations, submitting dental claims, continuing education as well as case review within our office and/or with your referring dentist/doctor. Photos for any advertising or public presentations will not be used without your permission and a separate from this consent form.
By signing below I agree to the above terms.

Signature _____ Date: _____

Information Release Form

Dr. Aaron Wilkins, requires that our staff obtain authorization from the patient to release and/or leave a detailed message for the patient. Secondary to the new HIPPA guidelines we need to guard against violating any patient confidentiality and protect our staff.

By signing below, I give my consent to Dr. Aaron Wilkins or his staff to release and/or leave messages regarding my care and/or upcoming appointments on my home and/or personal cell phone.

Signature: _____ Date:_____

Acknowledgement of Notice of Privacy Practices

I have been informed of and given the chance to receive and review a copy of the Notice of Privacy Practices of Stones Crossing Dentistry inc. I may request a copy at any time and acknowledge that there is a copy on display in the reception area.

Signature: _____ Date: _____