# ☺ *Welcome to Stratman Family Dentistry* ☺

**If you have any questions, or we can help you in any way, please feel free to ask!**

How did you hear about our office? Yellow pages Website Ads_____ Friend _____

Name: _____ I prefer to be addressed as:_____
Last First

Birthday: ___/___/____ Age:____ Male Female Social Security #:_____

Marital Status: Married Single Divorced Widowed

Home Address:_____
Street City State Zip

Home Phone:(____) _____ Work Phone: (____)_____

Cell Phone: (____) _____ E-mail address: _____

How would you prefer to be contacted? Home phone / Cell phone / Work phone

The best time to contact you is at: Morning / Afternoon / Evening

Employer: _____ Occupation:_____

Employer's Address: _____
Street City State Zip

If patient is a student: Name of school/college: _____

## Spouse/Parent Information

Name: _____ Birthday: ___/___/____ Social Security #:_____

Employer: _____ Work Phone:(____)_____

## Emergency Contact Information

Someone we may contact: _____ Phone #: _____

## Insurance Information

Name of Insured (Subscriber): _____ Birthday: ___/___/____

Dental Insurance Company: _____ Phone #: _____

Insured SSN#: _____ Subscriber ID # (if different from SSN):_____

## Method of Payment—required information

Since we are extending you a line of credit by filing and waiting for your insurance company to pay, we require an alternate form of payment for any additional balances. I authorize **Stratman Family Dentistry** to charge my credit card for any unpaid balance after the insurance payment. We will keep this information confidential as we do your medical records. If a balance remains after your insurance pays, a courtesy call will be made to you to inform you when and how much we will charge your credit card.

Credit Card: Visa MasterCard Discover American Express

Card Number: _____ Security Code: _____ Expiration Date: _____

# Medical History

Your current physical health is: Good Fair Poor
Do you have a personal physician? Yes No Physician's Name: _____
Are you currently under the care of a physician? Yes No If yes, please explain: _____
Do you smoke or use tobacco in any form? Yes No How many times per day? _____
Have you ever taken Phen-Fen, Redux or Pondimin? Yes No
Do you take any Homeopathic remedies? Yes No If yes, what?_____
For women: Are you taking Birth Control Pills? Yes No
Are you pregnant? Yes No If yes, how many weeks?_____
Please list any past surgeries:_____
**Please list any prescription or over the counter medications you are taking:** _____
_____
Have you ever been instructed to take antibiotics prior to dental visits? Yes No

**Do you have, or have you had, any of the following? (Please check every item)**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Yes | No | **Aids/HIV** | Yes | No | **Emphysema** | Yes | No | **Lung Disease** |
| Yes | No | **Alzheimer's** | Yes | No | **Epilepsy** | Yes | No | **Mitral Valve Prolapse** |
| Yes | No | **Anaphylaxis** | Yes | No | **Ever Hospitalized** | Yes | No | **Pace Maker** |
| Yes | No | **Anemia** | Yes | No | **Fainting Spells** | Yes | No | **Persistent Cough** |
| Yes | No | **Angina** | Yes | No | **Glaucoma** | Yes | No | **Postural Hypotension** |
| Yes | No | **Arthritis** | Yes | No | **Hay Fever** | Yes | No | **Psychiatric Problems** |
| Yes | No | **Artificial Heart Valve** | Yes | No | **Headaches** | Yes | No | **Radiation Treatment** |
| Yes | No | **Artificial Joint** | Yes | No | **Heart Attack** | Yes | No | **Rheumatic Fever** |
| Yes | No | **Asthma** | Yes | No | **Heart Murmur** | Yes | No | **Scarlet Fever** |
| Yes | No | **Blood Transfusion** | Yes | No | **Heart Surgery** | Yes | No | **Shingles** |
| Yes | No | **Cancer** | Yes | No | **Hemophilia** | Yes | No | **Sickle Cell Disease** |
| Yes | No | **Chemotherapy** | Yes | No | **Hepatitis** | Yes | No | **Sinus Problems** |
| Yes | No | **Chicken Pox** | Yes | No | **Herpes** | Yes | No | **Steroid Therapy** |
| Yes | No | **Chest Pains** | Yes | No | **High Blood Pressure** | Yes | No | **Stroke** |
| Yes | No | **Cold Sores** | Yes | No | **Kidney Problems** | Yes | No | **Thyroid Disease** |
| Yes | No | **Congenital Heart Defect** | Yes | No | **Leukemia** | Yes | No | **Tuberculosis** |
| Yes | No | **Cortisone** | Yes | No | **Liver Disease** | Yes | No | **Ulcers** |
| Yes | No | **Diabetes** | Yes | No | **Low Blood Pressure** | Yes | No | **Venereal Disease** |
| Yes | No | **Drug Abuse** | Yes | No | **Lupus** | Yes | No | **Other_____** |

**Comments**: _____

**Are you allergic to any of the following?**

| | | | | |
|---|---|---|---|---|
| ❑ Aspirin | ❑ Erythromycin | ❑ Latex | ❑ Sedatives | ❑ Tetracycline |
| ❑ Codeine | ❑ Jewelry/Metals | ❑ Penicillin | ❑ Sulfa Drugs | ❑ Other |

Please list anything additional that causes allergic reactions: _____
_____

## Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment at the time of services, any deductible, and co-payment that my insurance does not cover. I authorize Stratman Family Dentistry to charge my credit card for any unpaid balance after the insurance payment.

Patient (parent/guardian): _____ Date: _____

Dentist signature: _____ Date: _____

# Appointment Policy

At Stratman Family Dentistry we feel your time is as valuable to you as it is to us. We reserve time to focus on you and your dental health. We do not "overbook" and your appointment time is reserved exclusively for you. If you are unable to keep an appointment or find yourself running late, please notify us as soon as possible. This courtesy will allow us to be timely for other patients. We confirm your appointment two days prior to your appointment, and will leave a message if there is an answering machine or if someone else answers the phone. We will also attempt to send you an email a week in advance if you provide us with an email address. Therefore, **if you miss or cancel your appointment within 24 hours we reserve the right to charge you up to $50 per hour missed or may require a deposit to make any future appointments.** After excessive missed or cancelled appointments, you may be dismissed from our practice.

## Financial Policy

Payment for services is expected at the time service is provided. If treatment requires multiple appointments, payment may be divided over the number of appointments. We accept cash, checks and most major credit cards. We also offer CARE CREDIT, a healthcare finance plan that allows you to have interest free payments for up to 18 months if you qualify. For charges of $500 or greater, a 5% courtesy will be extended for full cash or check payment at time of service. If you have any questions, please feel free to ask.

I understand and agree that all services rendered to me, my dependents, or others assigned by me to my account are charged directly to me. I further understand I am personally responsible for payment. If I suspend or terminate care and treatment, any fees for services rendered will be immediately due and payable. Should the fees for the professional services not be paid, then you will be responsible for all fees we incur to collect. Finance charges can be applied to all past due amounts at the rate of 1.5% per month (18% annual rate). If the account is in default and turned over for collection, a collection fee will be added. If a check is returned for any reason there will be a $25 returned check fee added to your account balance, and checks will no longer be accepted for payment on your account.

**If you have dental insurance…**as a courtesy, we will file your primary (not secondary) claim for you. We may accept direct payment from most insurance companies. We will estimate your deductible and the portion not covered by your insurance, which is due at the time of treatment. Our estimates may be different than your insurance company's calculations; therefore, the amount due our office may be adjusted accordingly. All services rendered are charged directly to the patient, and **the patient is ultimately responsible for the account regardless of insurance coverage. Any insurance claims denied or remaining unpaid after 60 days will automatically become the responsibility of the patient.**

I agree to adhere to all Financial Policies and Appointment Policies.

_____ _____

Signature and Date Print Name

Stratman Family Dentistry

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, have received a copy of this office's Notice of Privacy Practices. I will allow the office to leave messages on my voice mail, answering machine or with someone else in my household regarding my dental appointments.

_____
{Please Print Name}

_____
{Signature}

_____
{Date}

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)