Patient Information

Last ______________________ First ______________________ MI___ (DR/MR/Mrs./MS/Miss)

Male/Female Married/Single DOB_____/_____/_____ Social Security # _____-_____-_____

Street ______________________ City ______________ State ________ Zip ____________

Home Phone ( ) ____________ Employer ______________________ Work Phone ( ) ____________

Name of Physician ______________________ Office Number ( ) ____________

In Case of Emergency Contact ______________________ Phone Number ( ) ____________

Email Address ____

Insurance Information

Insurance Company ______________________ Insurance Phone ( ) ____________ Group# ____________

Insured Last Name ______________________ First ______________________ MI___ (DR/MR/Mrs./MS/Miss)

Male/Female Married/Single DOB_____/_____/_____ Social Security # _____-_____-_____

Insured Employer ______________________________________ Employer Phone ( ) ____________

Dental Health Information-Confidential

Do you have a history of:	Yes	No
Rheumatic Fever	☐	☐
Heart Murmur	☐	☐
Heart Trouble	☐	☐
Pace Maker/Open Heart Surgery	☐	☐
High Blood Pressure	☐	☐
Low Blood Pressure	☐	☐
H.I.V. Positive	☐	☐
Diabetes	☐	☐
Stroke	☐	☐
Excessive Bleeding	☐	☐
Artificial Joints/Replacements	☐	☐
Anemia	☐	☐
Ulcers &/or stomach problems	☐	☐
Hepatitis	☐	☐
Lung Disease	☐	☐
Breathing Problems	☐	☐
Tuberculosis	☐	☐
Asthma	☐	☐
Tobacco Use?	☐	☐

	Yes	No
Fainting or dizziness	☐	☐
Venereal Disease	☐	☐
Arthritis	☐	☐
Kidney Disease	☐	☐
Liver Disease	☐	☐
Under Physicians care	☐	☐
Other Illness (explain below)	☐	☐
Trouble from previous dental care	☐	☐
Growths/sore spots in mouth	☐	☐
Ever had Novocain/local anesthetic	☐	☐
Ever had Nitrous Oxide	☐	☐
Ever had general anesthesia	☐	☐
Allergic reaction to Novocain	☐	☐
Any difficult extractions in the past	☐	☐
Do your gums bleed	☐	☐
Bad taste or odor in your mouth	☐	☐
Chew on one side of your mouth	☐	☐
Epilepsy (if yes answer below)	☐	☐

Date of last seizure? ____________

	Yes	No
Unhealed injuries or inflamed areas in your mouth	☐	☐
Any part of the mouth	☐	☐
Sensitive to pressure/cold/hot	☐	☐
Pain in jaw or ears	☐	☐
Popping/Clicking in jaw/TMJ	☐	☐
Treated/diagnosed w/TMJ	☐	☐
Sinus Problems	☐	☐

WOMAN NOTE

Is there a possibility of pregnancy? Y/N

Estimated due date ____________

Are you nursing? Y/N

Are you taking birth control pills? Y/N

*Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult with your doctor for assistance regarding additional methods of birth control.

Any other problems not listed above? (Please explain) ______________________

List any medications you are taking including non-prescription drugs

1.) ____________ 2.) ____________

3.) ____________ 4.) ____________

Are you allergic to any medications?

1.) ____________

2.) ____________

3.) ____________

LATEX ALLERGY?
Y / N

DENTAL HISTORY

1.) Date of last dental visit ____________

2.) Last dental x-rays? ____________

3.) If wearing dentures, age of dentures? ____________

4.) Reason for today's visit ____________

I certify that I have read and understand the questions above. I acknowledge that my questions have been answered to my satisfaction. I will not hold my dentist or any other member of his staff responsible for any errors that I have made in the completion of this form.

Parent/Guardian Signature ______________________ Date ____________

Stanich Family Dentistry

Financial Policies

Thank you for choosing Ronald Stanich DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of our mission is making the cost as affordable and manageable for our patients by offering several payment options, if needed.

We take all major credit cards: Visa, MC, AmEx and Discover.

We offer a 5% courtesy discount for those who pay for their services with cash or check

We offer CARECREDIT* for treatment plans over $300.00

Carecredit* makes it easy to start your work without worrying about paying upfront. There are 3, 6, 12 and 18 months no interest plans available. Our Office Manager will be happy to answer any of your CareCredit questions
*subject to credit approval

We work with all major dental insurances. You are responsible for any out-of pocket expense after your insurance company pays their portion of your treatment. We require your co-pay at the time the service is rendered.

There will be a $35.00 returned check fee.

If you have any questions about our financial policy, please ask the front desk, thank you.

____

Patient name **(please print)**

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Patient,Parent or Guardian **Signature** Date

STANICH FAMILY DENTISTRY, INC

NOTICE OF PRIVACY PRACTICES

I am acknowledging that I have received and know Dr Ronald Stanich's Privacy Practices. I am aware that if I want my Dental Records released to anyone but myself, I must sign the proper paperwork to give consent in order for any of my information to be shared.

Print Name ______________________________

Signature ______________________________

Date ______________________________