STONE ARCH **DENTAL**

8097 Highway 65 NE STE 104
Spring Lake Park, MN 55432
Office: 763-307-8689
Fax: 763-307-8649

Welcome to Stone Arch Dental

Patient Information

First Name ____________ Last Name ____________ MI ___ Preferred Name ____________

Street Address ____________ City ____________ State ______ Zip ______

☐ Male ☐ Female Date of Birth ____________ Social Security Number ____________

Home Phone ____________ Cell Phone ____________ Work Phone ____________ Receive Text Messages ☐ Yes ☐ No

Email Address ____________ Preferred Language ____________ How did you hear about our office? ____________

Emergency Contact ____________ Relationship ____________ Phone ____________

Responsible Party

(If the patient is a minor or does not make their own treatment decisions)

First Name ____________ Last Name ____________ MI ___ Relationship to patient ____________

Street Address ____________ City ____________ State ______ Zip ______

Home Phone ____________ Cell Phone ____________ Work Phone ____________ Receive Text Messages ☐ Yes ☐ No

Email Address ____________

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Stone Arch Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment will be due on any outstanding balance by 90 days from the date of each service, regardless of the status of any insurance claims. Failure to do so will result in your account being placed with our Account Management Firm. I authorize this office to contact and exchange information with credit agencies regarding any credit extended on my account as well as release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependents during the period of such dental care to third party payers and/or health practitioners.

Patient/Responsible Party Signature ______________________ Date ____________

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Financial Information

Financial Guarantor – If someone other than the patient/responsible party indicated on page one is responsible for payment please complete below.

First Name ______________________ Last Name ______________________ MI ____ Relationship to patient ______________

Street Address ____ City ______________________ State _________ Zip ________

Home Phone _______________ Cell Phone ______________ Work Phone ______________ Receive Text Messages ☐ Yes ☐ No

Email Address ____

Please select what is applicable to the patient

☐ Private Pay

☐ Medical Assistance

MA Number _________________________ Plan Name ______________________ Group Number _________________

☐ Dental insurance Information - Primary

Subscriber Name _____________________ Relationship to Patient ________________ Subscriber DOB __________

Subscriber SSN/ID ____________________ Subscriber Employer __________________

Insurance Company Name ____

Insurance Company Address ____

Insurance Company Phone ___________________ Group Number ___________________

☐ Dental insurance Information –Secondary

Subscriber Name _____________________ Relationship to Patient ________________ Subscriber DOB __________

Subscriber SSN/ID ____________________ Subscriber Employer __________________

Insurance Company Name ____

Insurance Company Address ____

Insurance Company Phone ___________________ Group Number ___________________

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Patient First Name ____________________ **Patient Last Name** ____________________ **Patient DOB** ________

Dental History

1. Previous Dentist: ________________ Phone: ________________ Address: ____________________
2. When did you last see a dentist? __________ X-rays taken? ______________________________
3. What was done at that time? ____
4. Was there any treatment recommended that you have not completed? ____________________
5. Are you currently in dental pain or have any concerns? ______________________________
6. Are you missing any teeth that you would like replaced? ______________________________
7. Are you dissatisfied with the appearance of your smile? ______________________________
8. Are your teeth sensitive? If yes please describe: _________________________________
9. Are you concerned with bad breath? ____
10. Have you ever had an injury to the face or mouth? ___________________________________
11. Are you aware of any TMJ problems? Does you jaw click, pop, grind, lock, or ache? ______________
12. Do you wear dentures or partials? If yes please specify: _______________________________
13. Do you have any concerns with your dentures/partials? If yes please specify: ________________
14. Have you ever been diagnosed or treated for gum disease? If yes please specify: ______________
15. Do you have any oral habits such as: thumb/finger sucking, suck/bite lip, bite/chew nails, chew hard objects (pencils, etc.), grind teeth, or clench jaws? If yes please specify: ________________________
16. Is there anything else that you would like the dentist to know? __________________________

Health History

Physician:________________ Clinic Name:________________ Phone: ____________ Last exam: ________
Address:____

1. Are you currently under the care of a physician? If yes please specify: ______________________
2. Has your physician recommended taking a pre-medication before dental treatment? ☐ Yes ☐ No
3. Please list your medications including over the counter:

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

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4. Are you allergic/sensitive to any of the following? If yes please describe the reaction:

   ☐ Aspirin ☐ Sulfa ☐ Codeine ☐ Local anesthetic ☐ Latex ☐ Penicillin/Amoxicillin ☐ Any Metal (nickel, silver, etc.)

   Other Allergies: ______________________________

   Reaction: ______________________________

5. (Women) Are you pregnant? ☐ Yes ☐ No Due Date: ____________ Are you Nursing? ☐ Yes ☐ No

6. Do you have, or have you ever had: (If yes, check the box)

☐ AIDS/HIV Positive
☐ Asthma
☐ Breathing Problems
☐ Alcohol Abuse (treated? ☐ Yes ☐ No)
☐ Drug Abuse (treated? ☐ Yes ☐ No)
☐ Artificial Bones/Joint Replaced?
☐ Clotting/Bleeding Problems
☐ Blood Pressure - High, Low, borderline? (Circle)
☐ Heart Attack(Myocardial Infarction)
☐ Heart Surgery Date: ________
☐ Heart Valve Replacement
☐ Pacemaker
☐ Atrial Fibrillation
☐ Congenital Heart Defect
☐ Tobacco: Cigarettes, Cigars, ECig, or Oral (Circle)
☐ Irregular Heartbeat
☐ Bruise Easily
☐ COPD
☐ Chronic Kidney Disease
☐ Cancer/Tumors/Leukemia
☐ Chemotherapy
☐ Hypoglycemia
☐ Diabetes – Type 1, Type 2, PRE (Circle)
☐ Hearing Impaired
☐ Hepatitis – Type A, Type B, Type C (Circle)
☐ Visually Impaired
☐ Head Injuries
☐ Fainting Spells
☐ Frequent Headaches/Migraines
☐ Jaw or Facial Surgery
☐ Anxiety
☐ Depression
☐ Bipolar
☐ Other Psychiatric Disorder – ____________________
☐ Learning: ADD/ ADHD/ Dyslexia (Circle)
☐ Autism
☐ Thyroid –Hyper (Overactive) or Hypo (Underactive). (Circle)
☐ Radiation Therapy
☐ Seizures/ Epilepsy – Controlled? ☐ Yes ☐ No
☐ Skin disorders/Rashes/Shingles
☐ Stroke: Major, TIA's (Mini)
☐ Poor or Delayed Healing
☐ Tuberculosis

Other Conditions: ______________________________

7. Have you ever had any other serious illness, hospitalizations or accidents? If yes, please specify.
   ____

8. Any previous surgeries? If yes, please specify and give dates.
   ____

9. Do you take or have you ever taken oral or IV Bisphosphonates? ______________________________

10. Do you have any special needs? If yes, please specify. ______________________________

Authorization for Treatment

I authorize the doctor and staff to perform any necessary dental services needed after diagnosis and oral discussion. I agree that the information filled out on this form is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form. I understand it is my responsibility to inform this office of any changes to the information I have provided, including medications.

Print Patient/ Responsible Party Name: ______________________________

Patient/Responsible Party Signature: ______________________________ Date ______________

Continue on to backside

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Appointment Policy

When an appointment is made, we are reserving that time just for you. Appointments are carefully scheduled so you'll be best served. Please be on time so we can perform all the treatment that has been scheduled. If you need to cancel or reschedule your clinic appointment, we require at least two (2) full business days before your appointment.

For example, if you have to cancel an appointment on Monday at 9 am, we need to know by the previous Thursday at 9 am.

What causes a Broken Appointment……

- Late cancelations (Less than two business days).
- Late arrival (10min).
- No show.

What causes Restrictive Scheduling…….

- New patient breaking an appointment
- Established patient breaking appointment for the 3rd time in a 12 month period

If you are on restrictive scheduling……..

- Appointments are only scheduled same day
- Future appointments already made (before restrictive scheduling) may be canceled

If you are on restrictive scheduling, we reserve the right to cancel future appointments. You are still welcome to receive your dental care from us by requesting "same day" appointments.

Appointment Confirmation

We send out reminders for your appointments. However, we consider your appointment CONFIRMED at the time the appointment is scheduled.

Name (print) ____

I have read the above policy, understand and agree to it terms

Signature: ____ Date________________

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Acknowledgement of Receipt of Notice of Privacy Practice Policies

I have received a copy of the Notice of Privacy Practices of Stone Arch Dental, PLLC. I hereby authorize, as indicated by my signature below, Stone Arch Dental, PLLC to use and disclose any protected health information (including copies of x-rays, and diagnostic records), as well as any and all information concerning my dental/medical care condition to third party payers and/or other health professionals.

____
Print Patient Name

____
Patient/Responsible Party Signature

____
Print Responsible Party Name

____
Date

Please list authorized persons with whom we may discuss your Protected Health Information (PHI) in addition to custodial and legal guardians:

Name	Relationship	Phone Number

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) ____