STONEBRIAR FAMILY DENTISTRY

Sanjukta Chitre, DDS ● 3685 Preston Road, Suite 145, Frisco, TX 75034● 972-377-5516 ● www.yourfriscodentist.com

WELCOME

Welcome to Stonebriar Family Dentistry. Our main goal is to help provide you with personalized, comprehensive care that is tailored to your unique dental needs and goals. We believe open communication builds the trust needed for long-lasting, trusting patient-doctor relationships. **Please fill out this form as completely as possible**. This will help us in making your transition to our office as smooth as possible.

ABOUT YOU:

Today's Date: ___________ How did you hear about us? _________________

Name (First, MI, last): ____

I prefer to be addressed as: ___________________Circle one: **Male Female**

Birthdate: ________________________Age:_____ SS #: ________________

Address: ____

City: ____________________________ State: ________ Zip: _____________

Email Address: ____

Home Phone: _____________________ Cell Phone: ____________________

Work Phone: ____

Employer: __________________________ Occupation: _________________

Employer's Address: ____

City: ____________________________ State: ________ Zip: _____________

Circle On: **Single Married Widowed Divorced Separated Partnered**

Spouse's Name: ____

Spouse's Birthdate: ____

When and where are the best times to reach you? __________________________

Other Family member's seen by us: ___________________________________

EMERGENCY CONTACT: (Specify a person who does not live in your house)

Name: ____________________________ Relationship: ____________________

Contact Number: ____

DENTAL HISTORY:

Why have you come to our office today? _________________________________

Are you in pain? **Yes No** If yes, for how long? _________________________

Previous Dentist: ____

Phone: _____________________ Last Visit Date: _________________________

Date of last Cleaning: __________ Date of last Dental X-rays: _______________

Have you ever been told you require antibiotics before dental treatment? **Yes No**

Have you ever had serious problems with any previous dental work? **Yes No**

How is your current dental health? ____

On a scale of 1-10 how would you rate your smile (10 being the best)? _________

DENTAL INSURANCE:

Person responsible for Account (if other than yourself): ___________________

Do you have dental insurance coverage: **Yes No**

Dental Insurance Co. Name: ____

Dental Insurance Co. Address: ______________________________________

City: ______________________ State: ________ Zip: ___________________

Dental Insurance Co. Phone: ____

ID #: ____________________ Group # ______________________________

Insured Name: (if not patient): ______________________________________

Relationship to patient: _______________ Insured's Birthdate: _____________

Insured's SS#: __________________ Insured's Phone: ___________________

Insured's Employer: _____________________Occupation: _______________

ACKOWLEDGEMENTS & SIGNATURES:

I acknowledge that the information I give in this form is to the best of my knowledge, and I understand that this information will be held in the strictest confidence. I also understand that it is my responsibility to inform this office of any changes in my insurance or medical status.

I understand that I will be required to pay my estimated portion of Dr. Chitre's fees at the time of treatment unless prior arrangements have been made. I also understand that I am ultimately responsible for payment of any and all services rendered, regardless of insurance reimbursement.

Signature:

____

Date:

____

Would you like whiter teeth? **Yes No**

Would you like straighter teeth? **Yes No**

What else about your smile would you like to change? ________________

Do you experience pain in your jaw joint (TMJ/TMD)? **Yes No**

Do you feel anxiety about dental treatment? **Yes No**

On an average how many times a day do you brush? ________________

How many times a week do you floss? ______

What type of tooth brush do you have**: Manual / Battery Operated/Electric**

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MEDICAL HISTORY

Patient Name: ______________________ Birth Date: ______________________

It is very important that we have an accurate record of your health status and any medication that you are currently taking. This at times can have a direct connection with dental findings and the treatment that you will receive. Thank you for answering the following questions.

	Yes	No	Please explain
Are you under a physician's care now?			
Have you been hospitalized in the last 2 years?			
Have you ever had a serious head or neck injury?			
Are you taking any medication(OTC or Prescription)?			
Have you ever taken Fosamax or any medication containing oral or IV bisphosphonates?			
Do you smoke or use tobacco?			
Do you use a controlled substance?			

FOR WOMEN ONLY:

	Yes	No
Are you Pregnant?		
Are you nursing?		
Are you taking Oral contraceptives		

ALLERGIES:

	Yes	No	Please explain
Aspirin			
Penicillin			
Latex			
Sulpha drugs			
Codeine			
Local Anesthetics			
Metal			
Other			

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

	Yes	No		Yes	No		Yes	No		Yes	No
Anemia			Chest Pains			Heart Murmur			Osteoporosis		
Anaphylaxis			Cold Sores			Pacemaker			Thyroid Disease		
Alzheimer's			Convulsions			Hepatitis B			Rheumatic fever		
Angina			Congenital HD			Hepatitis A or C			Tumors		
Arthritis			Cortisone Medication			High Blood Pressure			Tuberculosis		
Artificial Joints			Diabetes			High Cholesterol			Ulcers		
AIDS/HIV Positive			Drug Addiction			Hives			Venereal Disease		
Blood Disease			Emphysema			Hypoglycemia					
Blood Transfusion			Epilepsy			Kidney Problems					
Breathing problem			Excessive Bleeding			Leukemia					
Bruise Easily			Genital herpes			Liver Disease					
Cancer			Glaucoma			Low Blood Pressure					
Chemotherapy			Heart Attack			Mitral Valve Prolapse					

Have you ever had any serious Illness not listed above? **Yes / No**

If Yes, Please explain: ____

I have answered all the above questions accurately. I understand that DR. Chitre is basing her treatment taking into account the above information. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient, Parent or Guardian: ______________________ Date: ______________

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Patient Name: ____ Birth Date: ____

GENERAL CONSENT:

I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. If I am not diagnosed with any periodontal concerns, a preventive (regular) cleaning will be completed. By signing below, I am giving my consent to have radiographs taken and have a preventive(regular) cleaning done.

Signature of Patient, Parent or Guardian: ____ Date: _________________________________

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FINANCIAL AGREEMENT:

We are committed to providing you with the best dental care. Our fees reflect our professional commitment to excellence. If you have dental insurance, we are happy to help you receive your maximum allowable benefit. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

For your convenience we offer a wide range of financial options in order to pay for your dental treatment:

A) **Prepayment in Full**: For any treatment over $500, a prepayment courtesy of 5% will be given for direct payment in full by cash or check before or at the first treatment visit.

B) **Pay as You Go**: You may choose to pay your obligation for each visit with cash, check, or credit card at the visit.

C) **In-House Financing**: We offer No Interest Financing for up to 6 months with affordable monthly payments. There is a 5% management fee, NO CREDIT CHECKS and no prepayment penalties.

D) **Care Credit:** Care Credit offers No Interest financing for up to 24 months and low monthly payment options. There are no upfront costs, no prepayment penalties and no fees as long as it is paid in full by the end of the term. This allows you to get the necessary work done now and pay later.

In order to facilitate access to the very best dental care possible, you may choose from any of the following: Cash, Visa, MasterCard, American Express, Discover, Personal Checks or Care Credit (see above).

By law, insurance companies are required to make payment or deny a claim within 30 days. Please be aware that your dental benefit program is a contract between you, your employer and the insurance company. We are not a party to that contract. We file insurance claims as a courtesy to you, our valued patient. You are responsible (not your insurance company) for all fees for services rendered. We will gladly assist you in any way we can. I understand that if I become delinquent on my account, my account will be turned over to a collection agency. Please be aware that any parent or guardian bringing a child to our office is legally responsible for the payment of services rendered. After your dental insurance has paid for dental services rendered at Stonebriar Family Dentistry you may have an outstanding balance. This balance may include any deductibles, copayments, denials, and non-covered services. We do our best to estimate what you will owe.

I certify that I have read, fully understand, and accept the above financial policy.

Signature of Patient, Parent or Guardian: ____ Date: _________________________________

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APPOINTMENT POLICY:

At the Stonebriar Family Dentistry, we understand that your time is very valuable. We are constantly striving to make your experience here more pleasant than any other place you have previously been. Trying to accommodate every patient's individual needs and work schedule can be challenging. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call one to two days prior to your appointment. If you find that you cannot keep your appointment, we do require a minimum notice of 48 business hours so we are able to assist other patients with their dental needs. If our office is not notified within the 48 business hours, you will be subject to a **$50 per hour scheduled**, late cancellation charges.

By signing below, I agree to fulfill my obligation as a patient at the Stonebriar Family dentistry and agree to the "broken appointment" fee should I not give proper notification.

Signature of Patient, Parent or Guardian: ____ Date: _________________________________

____

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Patient Name: ____ Birth Date: ____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received, read and understand your Notice of Privacy Practices. I understand that this office has the right to change its Notice of Privacy Practices from time to time and that I may contact this office at any time at the above given address to obtain a current copy of the Notice of Privacy Practices. A copy of this signed, dated document shall be as effective as the original.

My signature will also serve as a PHI document release should I request treatment or radiographs be sent to other attending doctor / facilities in the future.

Patient Name: ____ Relationship to Patient: ____

Signature: ____ Date: ____

OFFICE USE ONLY

I attempted to obtain patient's signature in acknowledgement on the Notice of privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: ______________________________________ Initials: ________________ Reason: ____

____

CONSENT/ LIMITED AUTHORIZATION FOR ACCESS TO RECORDS:

Please list any other parties who can have access to your health information: (This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: ____ Relationship to patient: ____

Name: ____ Relationship to patient: ____

Name: ____ Relationship to patient: ____

I authorize the above mentioned people to have access to my medical and dental records including but not limited to my health history, radiographs, insurance and billing information and diagnosis and recommended treatment.

Signature: ____ Date: ____

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