Welcome to Our Practice This confidential information will help us prepare for your visit.

NAME _____
Mr Mrs Ms Rev Dr

I prefer to be addressed as _____

Birthdate ___/___/___ SS# _____-____-_____

Address _____ PO Box _____

_____ Zip _____

❑Single ❑Married ❑Divorced ❑Widowed ❑Separated

Home # _____ Work #_____Cell# _____

Employer _____

Address _____

Occupation _____ There for ___ yrs

Where and when is best to reach you? _____

Who referred you to our office? _____

Other family members seen by us _____

Last dental visit _____

Seen by Dr. _____ for _____

****

Spouse's Name _____

Birthdate ___/___/___ Work # _____

Employer _____

SS#(Spouse's)_____-_____-_____

Occupation _____ There for ____yrs

****

Account Information
Name on Account ❑Self ❑Spouse ❑Other
Payment Plan Preferred (please check one)

❑ Cash or personal check at time of treatment

❑ Visa, MasterCard or Discover at time of treatment

❑ I wish to establish credit with your office for personalized financial arrangements. I authorize a credit history report.

Why have you made this dental appointment?

_____

Why did you leave the office of your previous dentist?

_____

****

Please check one box in each section

❑ My mouth is very comfortable.
❑ My mouth is moderately comfortable.
❑ My mouth is uncomfortable.
❑ I think the appearance of my smile is excellent.
❑ I am satisfied with the appearance of my smile.
❑ I would like to change my smile.
❑ I am unconcerned about the appearance.
❑ I will do whatever I must to keep my teeth.
❑ I want to keep my teeth but only within a certain budget of time and money.
❑ I am indifferent about keeping my teeth.
❑ I have always done what was recommended to me.
❑ I have not done what was recommended to me.
❑ I have not had dentistry recommended to me.
❑ I put dental care high on my list for myself
❑ I put dental care low on my list.
❑ I have never considered where I put dental care.
❑ I think my present state of dental health is excellent
❑ I think my present state of dental health is good
❑ I think my present state of dental health is poor

****

Obstacles I see to having excellent dental care for myself...
If you select more than one of the following please number them in order of significance with #1 being that which is most significant for you at this time.

_____ I see no obstacles

_____ Time away from work or other obligations

_____ Fear of pain, *surgery*, or injections

_____ Fear because of past dental experiences

_____ The cost of treatment

_____ Other _____

PLEASE TURN OVER AND COMPLETE THE ADDITIONAL INFORMATION ON BACK ...

My current **MEDICAL** health is

❑ excellent ❑ good ❑ poor

Are you under the care of a physician? ❑ No ❑ Yes

Physician Name _____

Office location _____

Office telephone _____

List all medications you take (prescription and over counter)

_____

_____

Have you ever had the following

❑Heart Attack	❑Heart Surgery	❑Mitral Valve Prolapse
❑Heart Murmur	❑Pacemaker	❑Rheumatic fever
❑Scarlet Fever	❑Hepatitis	❑Kidney Problems
❑Cancer	❑Chemotherapy	❑Radiation Treatment
❑HIV / Aids	❑Shingles	❑Artificial Joint
❑Fever Blisters	❑Cold Sores	❑Artificial Valve
❑Stroke	❑Sinus Trouble	❑Epilepsy / Siezures
❑Diabetes	❑Tuberculosis	❑Psychiatric Problems
❑Ulcers	❑Colitis	❑Drug/Alcohol Dependence
❑Anemia	❑Asthma	❑Hemophilia / Bleeding
❑Arthritis	❑Emphysema	❑Venereal Disease
❑Fainting	❑Glaucoma	❑Difficulty Breathing

❑Hospitalized _____
❑High / Low Blood Pressure
❑Blood Transfusion
❑Severe or Frequent Headaches _____
❑Do you smoke or use smokeless tobacco?_____

Are you Allergic to or have had difficulty with any of the following substances....

❑Penicillin	❑Tetracycline	❑Latex
❑Aspirin	❑Codeine	❑Dental Anesthetic
❑Sulfa	❑Erythromycin	

❑Other Drugs _____

Do you exercise regularly ❑Yes ❑No

If YES what do you enjoy doing? _____

For Women

Are you taking birth control pills	❑No ❑Yes
Are you pregnant	❑No ❑Yes
Are you nursing	❑No ❑Yes

The information present on these pages is true to the best of my knowledge. The undersigned authorizes the doctor to take X-rays, study models, photographs, or other diagnostic materials deemed appropriate by the doctor to make a thorough diagnosis of my dental health condition. I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the services required for my dental health. I understand that the doctor will discuss treatment before it is initiated. I further authorize and consent that the doctor choose and employ such assistance as deemed fit.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written and signed financial arrangements have been made**. In the event of default I promise to pay interest on the indebtedness and any and all costs associated with collection of the delinquent account.**

All amounts 90 days past due are assessed 1.5% interest per month on the unpaid balance. _____(initial)

SIGNED _____DATE _____

Thank you for filling this form out completely. If you have questions regarding this form or any aspect of our dental practice please call.

Stine Family Dentistry ~ Dr. Roger Stine, DDS

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419-499-4991

1801 E. Perkins Avenue ~ Sandusky, Ohio 44870
419-626-4696

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As a courtesy to our valued patients, we will file claims for your insurance; **A SIGNED AND COMPLETED "SIGNATURE ON FILE FORM" IS REQUIRED FOR OUR FILES**. The responsibility of the insurance company is to you and it is your responsibility to see that you are reimbursed properly. Fees for services provided to insured patients are our usual and customary fees charged to all patients for similar services. Your policy may base its allowance on a fixed fee schedule determined solely by your insurance company. The percentage of the fee paid may therefore be different than the percentage you were told by your insurance company or than the percentage listed in your benefit booklet. Stine Family Dentistry, LLC does not participate with any insurance companies in the fee schedules it has developed. In deciding whom they should participate with the doctors have selected YOU. We will do our very best to see that you receive all of the benefits due you.