Welcome To Our Dental Office!

PATIENT INFORMATION

Name ____
First MI Last (Preferred Name)

Address_____________________________________ City________________ State_____ Zip________________

Birth Date______________ Email ______________________________ Marital Status: □ Minor □ Single □ Married

Phone #'s: Home _____________________ Work___________________ Ext_______ Cell _____________________

Emergency Contact Name/Phone #: ____

Employer Name/Address____

DENTAL INSURANCE INFORMATION

Primary

Name of Policy Holder______________________________________ Birth Date___________________________

Member ID #_______________________________________ Group #______________________________

Address (if different from above) ____

Employer Name____

Dental Insurance Company ____
Name Phone

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other

Secondary

Name of Policy Holder____ Birth Date________________________

Member ID #____________________________________ Group #______________________________

Address (if different from above) ____

Employer Name____

Dental Insurance Company ____
Name Phone

Patient's relationship to insured: □ Self □ Spouse □ Child □ Other

HOW DID YOU HEAR ABOUT OUR OFFICE?

- ☐ Insurance Company Participating Provider List
- ☐ Searched Online For "Dentist"
- ☐ Harford County Yellow Book
- ☐ Website (specify)_________________________
- ☐ Harford/Western Cecil County Yellow Book
- ☐ Saw Sign Over Door
- ☐ Referral From (Specify) _____________________
- ☐ Other (Specify)______________________________

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with ________________________________ Insurance Company(s) and assign directly to Dr. Michael E. Stratford 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. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ _____________________________ _______________
Responsible Party Signature Relationship Date

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I understand a copy of the Notice of Privacy Practices for this office, which contains a complete description of the uses and disclosures of my health information, will be made available at the time of my visit, and that this office has the right to change this Notice at any time, and I may contact this office at any time to obtain a current copy.

_____ I wish to receive the Notice of Privacy Practices ______I do not wish to receive the Notice of Privacy Practices

____ _____________________________ _______________
Signature Relationship Date

HEALTH HISTORY (Confidential)

DENTAL HISTORY

Date of last dental care_________ Date last dentures/partials made_________ Date of last dental X-rays_________

Check if you have had problems with any of the following:

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaw
□ Food collection between teeth
□ Grinding teeth
□ Loose teeth or broken fillings
□ Periodontal treatment
□ Sensitivity to cold
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sores or growths in your mouth

How often do you floss?_________________________ How often do you brush?________________________________
Do you play contact sports?______________________

MEDICAL HISTORY

Physician's Name____ Date of last visit_______________________________

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). □Yes □No

Have you had any serious illnesses or operations? □ Yes □ No If yes, describe__________________________________

Have you ever had a blood transfusion? □ Yes □ No If yes, give approximate dates_______________________________

(Women) Are you pregnant? □ Yes □ No Nursing: □ Yes □ No Taking birth control pills? □ Yes □ No

Check if you have had any of the following:

□ Anemia
□ Arthritis, Rheumatism
□ Artificial Heart Valves
□ Artificial Joints
□ Asthma
□ Back Problems
□ Blood Disease
□ Cancer
□ Chemical Dependency
□ Chemotherapy
□ Circulatory Problems
□ Cortisone Treatments
□ Cough, persistent
□ Cough up Blood
□ Diabetes
□ Epilepsy
□ Fainting
□ Glaucoma
□ Gout
□ Headaches
□ Heart Murmur
□ Heart Problems
□ Hemophilia
□ Hepatitis
□ High Blood Pressure
□ HIV/AIDS
□ Jaw Pain
□ Kidney Disease
□ Liver Disease
□ Mitral Valve Prolapse
□ Pacemaker
□ Radiation Treatment
□ Respiratory Disease
□ Rheumatic Fever
□ Scarlet Fever
□ Shortness of Breath
□ Skin Rash
□ Stroke
□ Swelling of Feet/Ankles
□ Thyroid Problems
□ Tobacco Habit
□ Tonsillitis
□ Tuberculosis
□ Ulcer
□ Venereal Disease

ALLERGIES

□ Aspirin
□ Barbiturates (Sleeping pills)
□ Codeine
□ Local Anesthetic
□ Penicillin
□ Sulfa
□ Latex
□ Other___________________

MEDICATIONS

List medications you are currently taking: ____

____

RELEASE

The above information is accurate and complete to the best of my knowledge. I will not hold Dr. Michael E. Stratford or any member of his staff responsible for any errors or omissions that I may have made in the completion of this form.

____ Signature

_____________________________ Date

Michael E. Stratford, D.D.S., P.A.

Medical Information Release and Authorization Form

Name: ___________________________________ Date of Birth: _____/____/_____

Authorization for Release of Information

[ ] I authorize the release of information including the entire contents of dental record, including diagnosis, treatment details and financial information.

This information may be released to:

[ ] Spouse___________________________________ Phone:___________________________

[ ] Child(ren)_________________________________ Phone: __________________________

[ ] Other____________________________________ Phone: __________________________

[ ] Information is not to be released to anyone.

I understand that I have the right to revoke this Authorization, in writing, at any time by notifying this office. Such revocation will not affect actions taken by the requesting person prior to the date he or she received the written revocation. I also understand information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and will no longer be protected by this rule. I understand that my health care provider cannot condition treatment on whether I sign this Authorization.
This Authorization will remain in effect until terminated by me in writing or until the following date (within one year of today's date): ____________________________.

Messages

Please call [ ] my home [ ] my work [ ] my cell number

You may also email me at:____

for purposes of communication regarding appointments or insurance. To opt out of receiving our newsletters or other marketing, check here: [ ]

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

Signed: ____ Date: ____/____/_____

Updated:

Michael E. Stratford, D.D.S., P.A.

Financial Policies

1. All fees are due at the time of service. If you do not have insurance, payment is due in full. If you do have insurance, we will file your claims; however, payment of the estimated deductible and co-payments are due at the time of service.
2. Most insurance companies pay benefits within 30 days. We will notify you by mail if there is any remaining balance on your part; payment of this bill is due within 30 days of receipt.
3. If for any reason your insurance company denies payment or pays less than our estimate of your benefits, you are responsible for any balance on your account.
4. We accept cash, MasterCard, Visa, Discover and checks.
5. We offer several financing options through CareCredit, including 6 or 12 month interest-free payment plans.
6. There is a $35 returned check fee.

Appointment Policies

1. We reserve approximately one hour of the doctor or hygienist's time for new patient appointments. It is critical that you arrive on time for your appointment. Please arrive 10 minutes ahead of your appointment time to complete registration forms if you have not already done so.
2. If you cannot keep an appointment for any reason, please call our office at least 48 <u>business</u> hours prior to your appointment time.
3. A $40 broken appointment fee will apply if you do not keep your appointment or cancel without sufficient notice.

I have read and agree to the above-stated policies.

Signed____ Date:___________________