Welcome To Stratford Family Dental!

Patient Information

Name _____ Birth Date_____
First MI Last (Preferred Name)

If minor, name of legal guardian(s) _____

Address_____ City_____ State_____ Zip_____

Phone #'s Home _____ Cell _____ Work_____ Ext_____

Email _____ Marital Status □ Minor □ Single □ Married

Employer Name/Address_____

How did you hear about our office?

☐ Insurance Company Participating Provider List
☐ Searched Online For "Dentist"
☐ Verizon Yellow Book
☐ Saw Sign Over Door
☐ Referral From (Specify) _____
☐ Other (Specify)_____

Confidential Health History

Dental History

_____	Yes	No
Are you apprehensive about dental treatment	☐	☐
Do you wear dentures	☐	☐
If so, how old are they _____		
Does food catch between your teeth	☐	☐
Do you have difficulty chewing food	☐	☐
Do your gums bleed easily or when you floss	☐	☐
Are your teeth sensitive	☐	☐
Are you dissatisfied with the color and/or appearance of your teeth	☐	☐
Do you have missing teeth you would like to replace	☐	☐
Do you clench or grind your teeth/jaws	☐	☐
Are you a habitual gum chewer or pipe smoker	☐	☐
Do you want complete dental care	☐	☐

_____	Yes	No
Do you wear a night guard	☐	☐
Do you play contact sports	☐	☐

How often do you brush _____

How often do you floss _____

Approximate date of last dental treatment _____

Approximate date of last dental x-rays _____

Any problems with previous dental treatment ☐ ☐

Reason for today's visit

_____

_____

Medical History

Physician's Name_____ Date of last visit_____

Check if you have, or have had, any of the following

Heart Problems
□ Blood pressure problems
□ Heart murmur
□ Heart valve problem
□ Mitral valve prolapse
□ Taking heart medication
□ Rheumatic fever
□ Pacemaker
□ Artificial heart valve

Blood Problems
□ Abnormal bleeding
□ Anemia
□ Ever require a blood transfusion

Allergy Problems
□ Hay fever
□ Sinus problems
□ Skin rashes
□ Taking allergy medication
□ Asthma

Bone or Joint Problems
□ Arthritis, Rheumatism
□ Back or neck pain
□ Joint replacement
(e.g.; hip, knee, pins, implants)

□ Ulcers

□ Kidney Disease

□ Cancer/Chemotherapy/Radiation treatment

□ **Premedication required by physician**

□ Tuberculosis, asthma or other respiratory disease

□ Diabetes

□ Fainting spells, seizures, epilepsy or other neurological disease

□ Stroke

□ Frequent or severe headaches

□ Thyroid problems

□ Persistent cough or swollen glands

□ Do you drink alcohol
If so, how much_____

□ Do you smoke, vape, chew tobacco
If so, how much_____

□ Hepatitis, jaundice or liver trouble

□ Herpes or other STD

□ HIV-positive/AIDS

□ Human Papilloma Virus

□ History of drug or alcohol abuse

Women	Yes	No
Are you taking contraceptives or hormones	☐	☐
Are you pregnant	☐	☐
If so, expected delivery date _____		
Are you nursing	☐	☐
Have reached menopause	☐	☐

Are you allergic or have you reacted adversely to the following:	Yes	No
Local anesthetics	☐	☐
Penicillin/other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex	☐	☐

Other _____

Please List All Medicines Taking

_____

_____

_____

_____

_____

Do you have any disease, condition, or problem not listed here that you feel we should know about? If so, describe

_____

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.

Patient/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Office Notes

_____

_____

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 for

Patient's Name _____

This information may be released to

[ ] Spouse _____ Phone _____

[ ] Child(ren) _____ Phone _____

[ ] Parent/Guardian(s) _____ 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) _____.

Patient/Guardian Signature _____

Whom should we call in case of emergency?

Name _____ Relationship _____ Phone _____

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

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

Patient/Guardian Signature _____ Date _____

Financial Information & Policies

Dental Insurance Information

Primary

Name of Policy Holder_____ Birth Date_____

Insurance Company_____ Member ID #_____ Group #_____

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

Secondary

Name of Policy Holder_____ Birth Date_____

Insurance Company_____ Member ID #_____ Group #_____

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

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.

Patient/Guardian Signature _____ Date _____

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 business 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.

Patient/Guardian Signature _____ Date_____