Just Smile

Dr. Michael Steinmetz dds
The only dentist your family will ever need.

PATIENT INFORMATION

DATE:___/____/____

Patient's name: _____ **Birth date**___/____/___ **Age**_____ ❑ **M** ❑ **F**
Mailing address: _____ **City** _____**State** _____ **Zip** _____
Email:_____ ❑ **Home phone** _____❑ **Cell phone** _____
Please check Primary Phone Contact preferred
Emergency Contact Phone #:_____ **Relationship to Patient:**_____
Patient's Employer: _____ **Patient SS #:** _____
Is Patient a minor child? Y N
Responsible Party:_____**Relationship to Patient:** ❑Self ❑Father ❑Mother ❑Other
Mailing address: _____**City** _____**State** _____ **Zip** ____
Responsible Party Employer:_____**Responsible Party Phone #**_____

**We appreciate referrals to our office! Whom may we thank for referring you to our office?*
❑ **Patient:**_____ ❑ **Website** ❑ **Internet Search** ❑ **Sign/DriveBy** ❑**Other**_____

INSURANCE INFORMATION

❑ I AM NOT COVERED BY DENTAL INSURANCE

Insured Name:_____**Relationship to Patient :**❑ **SELF** ❑ **SPOUSE** ❑ **PARENT** ❑ **OTHER**
DOB:__/____/___**Employer:**_____**Group#:**_____**Insured SS/ID number:** _____
Dental Insurance Carrier :_____ **Dental Insurance Phone #**_____

Is the Patient covered by Secondary's Insurance? ❑ **YES** ❑ **NO**
Insured Name:_____**Relationship to Patient :**❑ **SELF** ❑ **SPOUSE** ❑ **PARENT** ❑ **OTHER**
DOB:__/____/___**Employer:**_____**Group#:**_____**Insured SS/ID number:** _____
Dental Insurance Carrier :_____ **Dental Insurance Phone #**_____

I certify that the insurance information provided is accurate and that I, and/or my dependent(s) have dental insurance coverage listed above. I authorize the use of my signature on all insurance forms submitted to collect payment for dental services rendered on my behalf. I assign directly to the treating Dentist all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am responsible for all charges incurred during treatment and that my Insurance Carrier has the final determination on payment for all dental procedures according to my specific policy. This office will submit all dental forms and any additional information needed to your Insurance Carrier on your behalf to obtain the dental benefits. However, if your Insurance Carrier does not remit payment to this office 45 days after submission of your dental claim, you will be responsible for any balance on your account.

_____ _____

Please print name **Relationship of person filling out this form** **Signature of Parent/Guardian completing this form** **Date**

PATIENT PRIVACY POLICIES

*I acknowledge the receipt of this office's NOTICE OF PRIVACY POLICIES and I understand that I can request a copy of this policy at any time. I understand that this office will use my personal health information for the treatment, payment and/or health care operations. As required by law, our office adheres to written policies and procedures to protect the privacy of information about the patient that we create, receive, or maintain. Your answers on this form are for our records only and will be kept confidential subject to applicable HIPPA and State & Federal laws.*_____ _____

Signature of Patient/Guardian completing form **Date**

Dental History

Last Dental Cleaning_____
Former Dentist:_____
City/State:_____

Last Dental X-Ray:_____
X-Rays Taken at any other dental office? ❑ Y ❑ N
If **Yes name of Office**:_____
City/State_____

How often do you brush? ❑ 1x day ❑ 2x day ❑ _____
Do you smoke or use chewing tobacco? ❑ Yes ❑ No
How often do you floss? ❑ 1x day ❑ 2x day ❑ _____
Are you interested in stopping? YES NO SOMEWHAT
Do you have areas where food gets trapped/collects between teeth? ❑ Yes ❑ No
Is there anything you would like to see different about your teeth or that bothers you?_____

Please ✔ if you have had problems with any of the following Dental Issues:

❑ Bad Breath ❑ Bleeding Gums ❑ Blisters on lips/mouth ❑ Clicking /Popping of Jaw ❑ Dry Mouth
❑ Grinding Teeth ❑ Sensitivity to Cold ❑ Sensitive to Heat ❑ Sensitive to Sweets ❑ Canker Sores
❑ Sensitive to biting ❑ Periodontal (gum) Treatment ❑ Orthodontic Treatment ❑ Other_____

MEDICAL HEALTH HISTORY

❑ Y ❑ N **ARTIFICIAL JOINTS**
❑ **Knee** ❑ **Hip** ❑ **Heart Valve** ❑ **Other**_____
Date of replacement:_____
Surgeon:_____
Do you require Pre-Medication before Dental Visits? ❑Y ❑N

❑ Y ❑ N **Congenital Heart Lesions**
❑ Y ❑ N **Stroke** Date:_____
❑ Y ❑ N **Mitral Valve Prolapse**
❑ Y ❑ N **Heart Murmur**
❑ Y ❑ N **Scarlet Fever**
❑ Y ❑ N **Pacemaker**
❑ Y ❑ N **Heart Disease**

❑ Y ❑ N **Anemia**
❑ Y ❑ N **High Blood Pressure**
❑ Y ❑ N **Low Blood Pressure**
❑ Y ❑ N **Hepatitis Type:**_____
❑ Y ❑ N **Diabetes Type:**_____
❑ Y ❑ N **Kidney Disease**
❑ Y ❑ N **Liver Disease**
❑ Y ❑ N **AIDS or HIV**

❑ Y ❑ N **Cancer Type:**_____
❑ Y ❑ N **Radiation/Chemotherapy Treatment**
❑ Y ❑ N **Thyroid Problems**
❑ Y ❑ N **Tuberculosis**
❑ Y ❑ N **Herpes/Cold Sores Frequency**:_____
❑ Y ❑ N **Pregnant Due Date**:_____
❑ Y ❑ N **Alcohol/Chemical Dependency**
❑ Y ❑ N **Abnormal bleeding after extractions or surgery?**

Please note any condition, disease or medical problem not listed?

_____

_____

MEDICATIONS

Please ✔ any medications you are currently taking

☐ **Aspirin**
☐ **Anticoagulants (blood thinners)**
☐ **Antibiotics or sulfa drugs**
☐ **High blood pressure medicine**
☐ **Antidepressants or tranquilizers**
☐ **Insulin, Orinase, or other diabetes drug**
☐ **Nitroglycerin**
☐ **Cortisone or other steroids**
☐ **Osteoporosis (bone density) medicine**
☐ **List All Other Medications:**

_____

_____

_____

ALLERGIES

Please ✔ or list any Allergies to material/medicines

☐ **Penicillin or other Antibiotics** ☐ **Latex**
☐ **Local anesthetics ("Novocain")** ☐ **Sulfa**
☐ **Codeine or other narcotics** ☐ **Aspirin**
☐ **Barbiturates** (sleeping pills)_
☐ **Other Allergies:** _____

Name of Physician:_____
Physician Phone #:_____

Preferred Pharmacy:_____
Pharmacy Phone #:_____

_____
Printed Name of Person Completing form

_____
Signature of Person Completing form **Date**

STOP Please do not write in this area. This is for our Staff to update your Health History on future Dental Visits.

1 Today's Date:_____
Changes to your Health History as noted above? ☐ Y ☐ N

_____
Are you taking any new medications? ☐ Y ☐ N

_____

_____
Signature of Patient **Staff Initials**

2 Today's Date:_____
Changes to your Health History as noted above? ☐ Y ☐ N

_____
Are you taking any new medications? ☐ Y ☐ N

_____

_____
Signature of Patient **Staff Initials**

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Patient Financial Rights & Responsibilities

Dr. Steinmetz & his Staff are committed to provide our Patients the optimum in dental care! Payment for dental services provided is part of that process. We want to ensure that you are informed of our Financial Policy and your Patient Rights & Responsibilities. Please review the statements below and initial beside that you have been informed of the specific items of our Financial Policy. Our Staff is available for any questions you may have and thank you for choosing our Office to care for your Family's Dental needs.

_____Visa, MasterCard, Discover, CareCredit, Cash, and Check w/ proper ID are accepted forms of payment.
**Our banking institution will assess a $25.00 fee on any returned check s which will be added to your account.*

_____ Payment is due at the time dental services are provided unless alternate payment arrangements have been confirmed with our Office 48 hours in advance of your appointment. This is applicable for estimated co-payments if the patient has Dental Insurance Coverage, and Patients without Dental Insurance Coverage.

_____ An estimate of Dental Insurance Coverage (*if applicable)* obtained by our Staff does not guarantee payment of your dental claim. This information is an estimate only based on information provided by your Insurance Carrier.

_____ We will submit your Dental Insurance Forms (*if applicable)* and any required/requested information by your Dental Insurance Carrier to obtain your dental benefits.

_____ Your Insurance Carrier (*if applicable)* has the final determination of the specific dental benefits and materials covered under your policy when the claim is processed. Patients share the responsibility to be informed of their specific dental benefits.

_____ Any amount not paid by your Dental Insurance Carrier (*if applicable)* or any dental claim not resolved by your Dental Insurance carrier 45 days after the dental service was rendered will be the responsibility of the patient.

_____ Balances over 60 days will acquire finance charge periodic rate of 1.25% not to exceed 15% APR.

_____ Late Charges are assessed if the minimum payment requested on your statement is not received by the due date. The late charge will be $5.00 or 5% of the amount requested, whichever is greater, not to exceed $20.00.

_____ Delinquent Accounts of any unpaid balances over 150 days will be reported to a Collection Agency. Additional charges to your account may occur and will be added to the original unpaid balance.

Our Office adheres to the Patient Rights under **The Fair Credit Billing Act.** If you think you have been billed incorrectly, submit in writing to our office within 60 days of your first statement from our office in which the error or problem appeared. Please provide your name, account number, dollar amount of the suspected error, and describe the error, and if you can, explain why you believe there is an error. If you need more information, describe the item you are not sure about on your statement. You may call our office at 791-0030 to speak to our Staff but we will require written documentation of your concern if we are unable to resolve the matter via phone.
After we receive the written notice, we will acknowledge receipt of your written concern within 30 days unless we have already corrected the error. Our Office will provide an explanation or correction of these charges within 90 days of receipt of your written concern. No attempt will be made to collect the amount you question or report you as delinquent during the investigation. We can continue to bill you this amount while we are investigating and you are responsible to pay any amount of your bill that is not in question. If there was no mistake on our part, you will be responsible for payment of the account, including any finance charges. If you fail to pay this amount we can report you as delinquent.

I agree to be responsible for all charges rendered for dental services and materials. If I have Dental Insurance Coverage, I assume all responsibility for charges and materials not paid by my policy.

_____ _____

Signature of Patient/Responsible Party **Date**

A photocopy of this document may act as an original