PATIENT INFORMATION

Date_______________

Patient's Name_______________ Last _______________ First _______________ Middle

If patient is a minor, give parent's or guardian's name_______________

Address_______________ Street _______________ City _______________ State _______________ Zip

Email address_______________

Home Phone_______________ Cell Phone_______________ Work Phone_______________

Birthdate____/____/____ Age______ Social Security #_____-_____-_____

Employer_______________ Occupation_______________

Spouse's name_______________ Last _______________ First _______________ Middle

Employer_______________ Occupation_______________

Social Security #_____-_____-_____ Birthdate____/____/____ Work Phone_______________

RESPONSIBLE PARTY INFORMATION (If same as patient, skip to insurance information.)

Name_______________ Last _______________ First _______________ Middle

Residence_______________ Street _______________ City _______________ State _______________ Zip

Mailing Address_______________ Street _______________ City _______________ State _______________ Zip

Home Phone_______________ Cell Phone_______________ Work Phone_______________

Social Security #_____-_____-_____ Birthdate____/____/____ Relationship to patient_______________

Employer_______________ Occupation_______________

INSURANCE INFORMATION

Insured's Name_______________ Insured's SS#_____-_____-_____

Insured's Birthdate____/____/____

Insurance Company_______________ Group No._______________ Local No._______________

Address_______________ Street _______________ City _______________ State _______________ Zip

Insured's Employer_______________

Do you have dual coverage? ☐ Yes ☐ No Yes:

Insured's Name_______________ Insured's SS#_____-_____-_____

Insured's Birthdate____/____/____

Insurance Company_______________ Group No._______________ Local No._______________

Address_______________ Street _______________ City _______________ State _______________ Zip

Insured's Employer_______________

EMERGENCY INFORMATION

Name of nearest relative not living with you_______________

Complete Address_______________

Phone_______________

Whom may we thank for referring you to our office?_______________

Signature (Parent's signature if minor)_______________

Dental History

Do you have any present dental complaints? ______________________ Where? ______________

When was your last full-mouth X-ray taken? ______________________ Where? ______________

When was your last cleaning? ______________________ Where? ______________

Have you ever been instructed in the prevention of decay? ______________________

Have you ever been instructed in caring for your gums? ______________________

Would you like your teeth whiter? ______________________

DO YOU HAVE OR DO YOU USE ANY OF THE FOLLOWING - indicate with a check

- ☐ Teeth sensitive to cold, heat, or sweets
- ☐ Tooth pain when chewing
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent blisters on gums or mouth
- ☐ Jaw sounds
- ☐ Jaw muscle pain in the morning
- ☐ Complications from extractions
- ☐ Bad Breath
- ☐ Unpleasant taste
- ☐ Bleeding gums. How long?__________
- ☐ Food Impaction
- ☐ Periodontal Treatment
- ☐ Mouth breathing
- ☐ Oral habits, i.e. fingernail biting, thumb or finger sucking, of cheek, lips or tongue chewing, chew on pencils, pens.
- ☐ Cigarettes, pipe, or cigar smoking
- ☐ Injuries to mouth, teeth, or head
- ☐ Clenching
- ☐ Grinding
- ☐ Earaches
- ☐ Headaches
- ☐ Unfavorable dental experience

Medical History

Physician's Name ______________________ Date of Last Physical Exam ______________

Physician's Phone Number ______________________

Have you taken any medicine or drugs during the past year? ☐ YES ☐ NO

If yes, name of drug: ______________________

DO YOU HAVE OR HAVE YOU HAD ANY HISTORY OF THE FOLLOWING - indicate with a check

- ☐ Allergies ☐ Penicillin
  - ☐ Other antibiotics
  - ☐ Local anesthetics
  - ☐ other __________
- ☐ Required in past to take premed before dental appointment
- ☐ Heart murmur: When__________
- ☐ Artificial heart valves, heart stent, pacemaker
- ☐ Hepatitis ☐ Hepatitis vaccine
- ☐ Heart disease
- ☐ Mitral valve prolapse
- ☐ Reumatic fever
- ☐ Immunocompromised
- ☐ AIDS/HIV positive
- ☐ Joint replacement
- ☐ Fen Fen Use
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Taking blood thinner/coumadin, etc.
- ☐ Excessive bleeding from cut or extraction
- ☐ Anemia with blood problem
- ☐ Neurological problems
- ☐ Epilepsy or convulsions
- ☐ Psychiatric care/emotional problems
- ☐ Cancer
- ☐ Radiation treatment
- ☐ Tumor History
- ☐ Tuberculosis
- ☐ Sinus problems
- ☐ Kidney problems
- ☐ Liver problems
- ☐ Scarlet fever
- ☐ Veneral Disease
- ☐ Herpes
- ☐ Arthritis
- ☐ Diabetes

Female Patient ONLY: Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No

Please describe any serious injuries, illnesses, impending medical treatment, operations, or any other medical or dental information that may possibly affect your dental treatment: ______________________

____

____

Updates (date & initial)__________/__________/__________/__________/__________/__________

James A. Striebel DDS
dentistry

Ph: (937) 235-2400
Fx: (937) 235-8070

www.drstriebel.com
info@drstriebel.com

7391 Brandt Pike
Huber Heights, OH 45424

Financial Policy

Payment Terms

We require your deductible and estimated co-payment to be paid at the time of your visit. As a courtesy to you, we will submit your insurance claims. For extensive treatment plans, we offer payment plans with prior credit approval.

Insurance

Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party that contract. Our relationship is with you, not your insurance company. We cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charges. Our involvement will be limited to supplying factual information to facilitate the claim processing.

All charges are your responsibility whether the insurance company pays or does not pay. Not all services are a covered benefit in all contracts. **Some insurance companies arbitrarily select certain services they will not cover.**

If your insurance company does not pay your claim within 45 days, it is your responsibility to contact your insurance company to expedite payment. If your insurance company does not pay, you are responsible for your payment.

Employees of James A. Striebel DDS Inc. are NOT representatives of your insurance company and the estimate you receive from us is not a guarantee of payment from your insurance company. It is your responsibility to inform us of any changes in your benefit coverage.

As our patient, you authorize payment from your insurance carrier to be made directly to the dentist. .

Financing

You are welcome to choose from our payment options should you require extensive treatment. For your convenience, we offer several methods of payment: **cash, check or charge** (Mastercard, VISA, American Express, Discover).
CareCredit offers 12 month no interest and 24, 36, 48 months at low interest.

Delinquency

A finance charge of 1 ½% per month (18% per annum) will be charged on unpaid balances over 60 days. If a collection agency is needed to collect your account, then their fees will be added to your balance. There will be a fee of $30 for returned checks.

I have read, understand and agree to the provisions of this financial policy.

____ ______________

Signature *Date*

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Acknowledgement of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment"

I, ____, have received a copy of this office's Notice of Privacy Practice.

- I understand that I may inspect or copy the protected health information described by this authorization.

- I understand that, at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my health care will not be affected if I refuse to sign this form.

- I understand that information used or disclosed, pursuant to this authorization, could be subject to redisclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

Regarding appointment and personal information:
Do we have permission to leave messages at

- ○ Home
- ○ Work
- ○ Cell Phone
- ○ None of the above

Please list anyone NOT authorized to share your information with:

____

Please give us the best way to contact you: ____

_____________________ ____

Date Signature of Individual or Representative