



Patient Information

A B C

Date _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Phone _____ Email _____
Cell Home Work

Best Time to Call _____ Best Phone to reach you _____

May we contact you thru: _____ Email or _____ Text Message?

Whom may we thank for referring you? _____

Preferred Appointment Times:
_____ Morning _____ Afternoon _____ Mon _____ Tues _____ Wed _____ Thurs _____ Fri _____ Sat

Social Security # _____ Birthdate _____ Marital Status _____

Employer _____ Occupation _____ No. of years Employed _____

Spouse's Name _____
Last First Middle

Social Security # _____ Birthdate _____ Work Phone _____

Employer _____ Occupation _____ No. of years Employed _____

Who is responsible for this account? _____

Insurance Information

Insured's Name _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Phone No. _____

Do you have secondary coverage? ___ Yes ___ No If yes:

Insured's Name _____

Insurance Company _____ Group No. _____

Insurance Co. Address _____ Phone No. _____

Assignment and Release

I understand I am responsible for my account regardless of my insurance. I understand that my insurance is an agreement between me and my insurance company. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize release of information to secure payment of benefits. I authorize the use of this signature on all insurance claims.

Responsible Party Signature _____ Relationship _____ Date _____

Medical History

Physician's name: _____ Date of last visit _____

Have you had any of the following:

- | | | |
|---|--|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Fainting or dizziness | <input type="checkbox"/> Shortness of breath |
| <input type="checkbox"/> Alzheimer's disease | <input type="checkbox"/> Headaches, migraines | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Arthritis, rheumatism | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> AIDS, HIV | <input type="checkbox"/> Heart valve problems | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Artificial heart valves | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Swollen neck glands |
| <input type="checkbox"/> Artificial joints | <input type="checkbox"/> Hepatitis, type _____ | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Herpes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Tumor or growth on head or neck |
| <input type="checkbox"/> Back problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Reflux, heartburn |
| <input type="checkbox"/> Bleeding abnormally after extractions or surgery | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Venereal disease |
| <input type="checkbox"/> Blood disease | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Hospitalized in last 2 years |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Illness or impending medical treatment that may affect your dental treatment _____ |
| <input type="checkbox"/> Chemical dependency | <input type="checkbox"/> Liver disease | _____ |
| <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Low blood pressure | _____ |
| <input type="checkbox"/> Chest pain upon exertion | <input type="checkbox"/> Mitral valve prolapse | _____ |
| <input type="checkbox"/> Circulatory problems | <input type="checkbox"/> Neurological problems | _____ |
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Pacemaker | |
| <input type="checkbox"/> Cortisone treatments | <input type="checkbox"/> Psychiatric care | |
| <input type="checkbox"/> Persistent or bloody cough | <input type="checkbox"/> Radiation treatment | Women: |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Respiratory disease | <input type="checkbox"/> Pregnant, due date _____ |
| <input type="checkbox"/> Epilepsy, convulsions | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Nursing |
| | <input type="checkbox"/> Sleep disorder | <input type="checkbox"/> Taking birth control pills |

Please list the medications you are currently taking: _____

Pharmacy Name _____ Phone _____

Allergies

- | | | | |
|----------------------------------|---|--------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Latex | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Motrin | <input type="checkbox"/> Local anesthetic | <input type="checkbox"/> Metal | _____ |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Penicillin | | _____ |

My medical history is accurate and complete. I understand it is my responsibility to inform the dental office of any changes in my medical status. I give permission for my dentist and clinical team to take any necessary xrays, photos, and study models to make a complete diagnosis of my dental needs. I consent to use my dental information to obtain insurance payment.

Parent or Guardian's Signature _____ Today's Date _____

Updates (date & initial) _____

In case of emergency please contact (someone not living with you):

Name _____ Relationship to you _____

Address _____ Phone _____

Dental History

Reason for today's visit _____

Date of last dental visit _____ Date of last dental Xrays _____

Do you have any of the following:

- Teeth sensitive to cold, heat, or sweets
- Teeth sensitive when chewing
- Bleeding or swollen gums
- Loose teeth
- Food collecting between teeth
- Broken fillings
- Grinding or clenching teeth
- Clicking or popping of the jaw
- Jaw tiredness
- Pain around your ear
- Burning of the tongue
- Sores or swellings in your mouth
- Bad breath
- Complication from extractions
- Problems during previous dental work
- Cigarettes, pipe, or cigar smoking
- Chewing tobacco
- Dry mouth
- Blisters on lips or mouth
- Lip or cheek biting

Do you like your smile? _____

How often do you brush? _____

How often do you floss? _____

John R. Striebel, D.D.S.

Financial Policy

We ask that all patients read and sign our Financial Policy prior to seeing the dentist. Payments for services are due at the time they are rendered. For extensive treatment plans, we offer payment plans with prior credit approval.

We may accept assignment of insurance benefits, however, please understand that:

1. **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.
2. Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to 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.
3. 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.
4. If your insurance company does not pay your claim within 30 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.
5. Employees of John R. Striebel, D.D.S., 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.
6. Balances older than 60 days will be turned over to a collection agency.
7. There will be a fee of \$30 charged for returned checks. Charges may be incurred for missed appointments.
8. You authorize payment from your insurance carrier to be made directly to the dentist.
9. You authorize this office to release necessary medical or dental information about you to your insurance carrier.

Thank you for taking the time to read and understand our financial policy. We are committed to providing exceptional care for our patients. If you have any questions regarding your treatment or available financing, feel free to ask. We will be glad to help.

We appreciate your trust and the opportunity to serve you.

Patient or Guardian's Signature

Today's Date