Stone Ridge DENTAL
CURT CARPENTER, D.D.S.

Patient Registration Form

Patient Name:_____ Preferred Name:_____
Address:_____
City:_____State:_____Zip:_____
Home Phone:_____Work Phone:_____
Cell Phone:_____Email Address:_____
Preferred Method of Contact: ☐ Text:_____ ☐ Email:_____
Birthdate:_____ Sex: ☐ M ☐ F
Soc. Sec. #:_____ Marital Status:_____
Employer:_____

Spouse:_____Employer:_____
Emergency Contact Person:_____Phone #:_____
How did you hear about our office?_____

Insured or Responsible Party Information

Name:_____ Relationship:_____
Address:_____ City, State, Zip:_____
Soc. Sec. #:_____ Phone #:_____
Birthdate:_____ Employer:_____

(PRIMARY COVERAGE)
Dental Insurance Co.:_____
Address:_____ City, State, Zip:_____
Phone #:_____ Group #:_____
Subscriber Name:_____ Birthdate:_____ID#:_____

(SECONDARY COVERAGE)
Dental Insurance Co.:_____
Address:_____ City, State, Zip:_____
Phone #:_____ Group #:_____
Subscriber Name:_____ Birthdate:_____ID#:_____

I understand and agree that regardless of insurance status, I am completely responsible for payment of my account for the services rendered. I certify that the above information is true and correct. This signature on file is my authorization for the release of my information necessary to process any of the insurance benefits. My signature authorizes that all insurance benefits are to be made payable directly to Stone Ridge Dental. This office reserves the right to verify the credit status of potential patients and/or parents of the patient prior to extending credit for the treatment. At the discretion of the office we may use the service of one or more credit reporting agencies.

Signature:_____ Date:_____

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Patient Health Questionnaire

Although dental personnel primarily treat the area in and around the mouth, your mouth is part of your entire body. Health conditions that you have, or medications that you take have an important interrelationship with the dentistry you receive. Thank you for answering the following questions.

What is your main dental need?_____

Are you under a physician's care now?	Yes/No	If Yes, please explain:_____
Have you ever been hospitalized or had a major operation?	Yes/No	If Yes, please explain:_____
Have you ever had a serious head or neck injury?	Yes/No	If Yes, please explain:_____
Are you taking any medication, pills, or drugs?	Yes/No	If Yes, please explain:_____
Do you use tobacco?	Yes/No	If Yes, please explain:_____
Do you use controlled substances?	Yes/No	If Yes, please explain:_____
Do you take, or have you taken Phen-Fen or Redux?	Yes/No	If Yes, please explain:_____
Have you ever taken FOSAMAX, BONIVA, ACTONEL or any other medication containing Bisphosphonates?	Yes/No	If Yes, please explain:_____
Have you ever pre-medicated prior to a dental appointment?	Yes/No	If Yes, please explain:_____

Women: Are you Pregnant/Trying to get pregnant? Yes/No Taking oral contraceptives? Yes/No Nursing? Yes/No

Are you allergic or had a reaction to any of the following? If yes, please MARK ALL that apply.

☐ Dental Anesthetics ☐ Penicillin ☐ Codeine ☐ Sulfa Drugs ☐ Metal ☐ Aspirin ☐ Latex

Other:_____ If Yes, please explain:_____

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes/No	Convulsions	Yes/No	Heart Murmur	Yes/No	Recent Weight Loss	Yes/No
Alzheimer's Disease	Yes/No	Cortisone Medicine	Yes/No	Heart Pace Maker	Yes/No	Renal Dialysis	Yes/No
Anaphylaxis	Yes/No	Diabetes	Yes/No	Hemophilia	Yes/No	Rheumatic Fever	Yes/No
Anemia	Yes/No	Drug Addiction	Yes/No	Hepatitis A	Yes/No	Rheumatism	Yes/No
Angina	Yes/No	Easily Winded	Yes/No	Hepatitis B or C	Yes/No	Scarlet Fever	Yes/No
Arthritis/Grout	Yes/No	Emphysema	Yes/No	Herpes	Yes/No	Shingles	Yes/No
Artificial Heart Valve	Yes/No	Epilepsy or Seizures	Yes/No	High Blood Pressure	Yes/No	Sickle Cell Disease	Yes/No
Artificial Joint	Yes/No	Excessive Bleeding	Yes/No	Hives or Rash	Yes/No	Sinus Troubles	Yes/No
Asthma	Yes/No	Excessive Thirst	Yes/No	Hypoglycemia	Yes/No	Spina Biffida	Yes/No
Blood Disease	Yes/No	Fainting	Yes/No	Irregular Heart Beat	Yes/No	Stomach/Intestinal	
Blood Transfusion	Yes/No	Spells/Dizziness	Yes/No	Kidney Problems	Yes/No	Disease	Yes/No
Breathing Problems	Yes/No	Frequent Cough	Yes/No	Leukemia	Yes/No	Stroke	Yes/No
Bruise Easily	Yes/No	Frequent Diarrhea	Yes/No	Liver Disease	Yes/No	Swelling of Limbs	Yes/No
Cancer	Yes/No	Frequent Headaches	Yes/No	Low Blood Pressure	Yes/No	Thyroid Disease	Yes/No
Chemotherapy	Yes/No	Genital Herpes	Yes/No	Lung Disease	Yes/No	Tonsillitis	Yes/No
Chest Pains	Yes/No	Glaucoma	Yes/No	Mitral Valve Prolapse	Yes/No	Tuberculosis	Yes/No
Cold Sores/Fever		Hay Fever	Yes/No	Pain in Jaw Joints	Yes/No	Tumors or Growths	Yes/No
Blisters	Yes/No	Heart Attack/Failure	Yes/No	Parathyroid Disease	Yes/No	Ulcers	Yes/No
Congenital Heart		Heart Trouble/		Psychiatric Care	Yes/No	Venereal Disease	Yes/No
Disorder	Yes/No	Disease	Yes/No	Radiation Treatment	Yes/No	Yellow Jaundice	Yes/No

Have you ever had any serious illness not listed above? Yes/No If Yes, please explain:_____

Comments:_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in medical status.

Print: Patient Name:_____ Signature of Patient or Guardian:_____Date:_____

Doctor Signature:_____Date:_____

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No Show/Late Cancellation Policy

This policy has been established to help us serve you better

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of dental care to other patients, some who are in a lot of pain.

A "no-show" is missing a schedules appointment. A "late-cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of your reserved appointment time.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case-by-case basis.

A possible charge of $50.00 could be assessed for each no-show or late-cancellation of your reserved appointment if less than 24 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

_____ _____

Date Signature

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Our first priority is to provide you with quality dental care at an affordable cost.

Insurance Coverage:
We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. We gladly provide you with an **estimate** of your co-payment.

Payment is due at the time of service. We accept cash, check, and major credit cards.

- ☐ **Cash or check**
- ☐ **Major Credit Cards**
- ☐ **CareCredit (Subject to Credit Approval)**

Missed Appointments:
If you are unable to keep your scheduled appointment, we request that you give us **48 hour notice**, otherwise we do reserve the right to charge you **$50 for the time you had reserved**.

Payment Options:

1. Pay full estimated patient portion on date of service and receive a 5% courtesy adjustment.
2. We also have a payment plan called CareCredit. This allows you to start treatment today and spread payment between 6 to 12 months.
    - Applying for CareCredit only takes a few minutes and there is no fee to apply. If credit application is declined, another form of payments listed is required.
3. Pay your estimated co-payment including deductible at the time of service.

    Finance Charges:
    If no payment arrangements are made, a finance charge of up to 21% may be applied to balances not paid within 30 days.
    Past Due Account:
    If your account is 60 days past due and your account is referred to a collection agency, you agree to pay the collection costs which are incurred. If we refer collection of the balance to an attorney, you agree to pay all attorney fees which we incur plus all court costs.

Returned Checks:
There is a fee (currently $25) for any checks returned by the bank.

Divorce:
In case of divorce or separation, the responsible party who brings the child is responsible for payment.

Patient's name: _____ Responsible Party (If not Patient):_____

Signature: _____ Date: _____

I have received the Privacy Policy for Stone Ridge Dental.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice Of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communication barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please specify)

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Patient Values & Objections

Please check the boxes of any that apply.

What do you value most in relation to your oral health?

- ☐ Cosmetic
  The appearance of your smile
- ☐ Function
  Chewing properly; fit of teeth, jaw function
- ☐ Comfort
  Any pain or discomfort
- ☐ Longevity
  Teeth & treatment done lasting for a long time

When considering having treatment done, which of these would be a concern to you?

- ☐ Fear
  A previous bad experience, noises, environment
- ☐ Time
  No time in my schedule for appointments
- ☐ Trust
  Seeking second opinion, feel treatment is unnecessary, previous bad experience
- ☐ Budget
  Financial concerns
- ☐ No sense of urgency
  Haven't seen a dentist in years, don't see why the work needs done, don't feel any pain
- ☐ Other
  _____
  _____