Stone Creek Dental

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to call us.

Last Name / First Name / Initial	Social Security No.	Tx. Driver License No.	
Residence / City / State / Zip		Phone	
Party Responsible or Guardian / Phone	Name of Physician	Phone	Patient Date of Birth
Employment	Position	Business Phone	
Nearest Relative not living with you / Address		Phone	Relationship
Dental Insurance / Group No.	Company Address	Policy Holder	S.S.No.

I Authorize release of any information necessary to process dental claim.

I hereby authorize payment directly to the below named Dentist of the Group Insurance Benefits otherwise payable to me.

Signed (patient or parent if minor ____ Date ____

Signed (insured person) ____ Date ____

E-Mail Address	Cell Phone	Referred by	Date of Last Dental Exam & Cleaning

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now? ○ Yes ○ No ○ N/A ____
- Have you ever been hospitalized or had a major operation? ○ Yes ○ No ○ N/A ____
- Have you ever had a serious head or neck injury? ○ Yes ○ No ○ N/A ____
- Are you taking any medications, pills or drugs? ○ Yes ○ No ○ N/A ____
- Do you take, or have you taken, Phen-Fen or Redux? ○ Yes ○ No ○ N/A
- Do you use tobacco? ○ Yes ○ No ○ N/A
- Are you on a special diet? ○ Yes ○ No ○ N/A
- Do you use controlled substances? ○ Yes ○ No ○ N/A

Women: Are you ○ Pregnant or Trying to get pregnant? ○ Nursing ○ Taking oral contraceptives

Are you allergic to any of the following?
○ Aspirin ○ Penicillin ○ Codeine ○ Acrylic ○ Metal ○ Latex ○ Local Anesthetics ○ Other ____

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

○ AIDS / HIV Positive	○ Chest Pain	○ Frequent Headaches	○ Irregular Heartbeat	○ Scarlet Fever
○ Alzheimer's Disease	○ Cold Sores / Fever Blisters	○ Genital Herpes	○ Kidney Problems	○ Shingles
○ Anaphylaxis	○ Congenital Heart Disorder	○ Glaucoma	○ Leukemia	○ Sickle Cell Disease
○ Anemia	○ Convulsions	○ Hay Fever	○ Liver Disease	○ Sinus Trouble
○ Angina	○ Cortisone Medicine	○ Heart Attack / Failure	○ Low Blood Pressure	○ Spina Bifida
○ Arthritis / Gout	○ Diabetes	○ Heart Mummer*	○ Lung Disease	○ Stomach/intestinal Disease
○ Artificial Heart Valve*	○ Drug Addiction	○ Heart Pace Maker*	○ Mitral Valve Prolapse*	○ Stroke
○ Artificial Joint*	○ Easily Winded	○ Heart Trouble / Disease	○ Pain in Jaw Joints	○ Swelling of Limbs
○ Asthma	○ Emphysema	○ Hemophilia	○ Parathyroid Disease	○ Thyroid Disease
○ Blood Disease	○ Epilepsy or Seizures	○ Hepatitis A	○ Psychiatric Care	○ Tonsillitis
○ Blood Transfusion	○ Excessive Bleeding	○ Hepatitis B or C	○ Radiation Treatment	○ Tuberculosis
○ Breathing Problem	○ Excessive Thirst	○ Herpes	○ Recent Weight Loss	○ Tumor or Growths
○ Bruise Easily	○ Fainting Spells Dizziness	○ High Blood Pressure	○ Renal Dialysis	○ Ulcers
○ Cancer	○ Frequent Cough	○ Hives or Rash	○ Rheumatic Fever*	○ Venereal Disease
○ Chemotherapy	○ Frequent Diarrhea	○ Hypoglycemia	○ Rheumatoid Arthritis	○ Yellow Jaundice

Have you ever had any serious illness not listed above? ○ Yes ○ No ○ N/A ____

Comments ____

Doctor's Signature ____ Date ____

We are governed by the
State Board of Dental Examiners
333 Guadalupe • Tower 3, Suite 800
Austin, Texas 78701
(512) 463-6400

What is the main problem that brought you to our office? ____

Please add anything about your medical or dental history you feel is important for us to know about ____

Stone Creek Dental

OFFICE POLICIES

Insurance Policy:

As a courtesy to you, we will be filing your insurance. The charge that you will be responsible for today will be an estimation of coverage based on what we have received from verifying your individual plan with your insurance company.

Most insurance companies do not guarantee coverage, so if your insurance company does not pay us as expected, you will be responsible for the remaining balance.

If you do not wish to sign this agreement, you can pay in full based on your insurance companys' fee schedule and file for insurance reimbursement on your own with our itemized receipt that we will provide to you.

I, ____, understand that I will be responsible for any fees not paid by my insurance company as noted above and agree to pay Stone Creek Dental any balance left after my insurance considers and acts on my claim.

OR

I, ____, wish to file for insurance reimbursement on my own.

Appointment Policy:

*******We require a 48-hour notice for cancellations of appointments***.

(Office closed weekends, Inform of appointment changes Mon.-Fri.)

In the event of a missed appointment or late cancellation your account will be charged a minimum fee of ***$30.00***.
We try our best to run on time as a courtesy to our patients, if you are late please give our office a call as soon as possible.
Your insurance carrier will not cover any fees-assessed pertaining to this policy.

I have read Stone Creek Dental's policies and agree to abide by them.

Patient/ Guardian Signature:_____________________ Date:______________