Welcome

Downtown Dental Care
Gregory L. Stafford DDS, PA
Michael D. Zweifler DDS

Please fill out this form completely, it is important for your care

ABOUT YOU

Today's Date: ____________________ ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Widowed

Name: ____ ☐ M ☐ F Birthdate: ____/____/____ Age:____ SSN:_______________________
LAST FIRST MI

Home Address____
CITY STATE ZIPCODE

Home #: ( ) _______________ Cell #: ( )________________ Work #: ( )_________________ DL #:_______________________

E-Mail Address: ____ When is the best time to reach you? ______________________________

Who may we thank for referring you? ______________________________ Other family seen by us____

Employer: ____ How long there? _______________ Occupation: _______________________________

In the event of an emergency, who should we contact

Name: ____ Relation: ____

Work #: ( ) _______________________ Home #: ( ) ________________________ Cell #: ( ) ______________________

SPOUSE INFORMATION

Name: ____ Birthdate:______/_______/_______ SSN:_______________________________

Employer: ____ Cell #: ( ) ________________ Work #: ( ) ________________

Person Responsible for Account, if other than yourself

Name: ____ Relation: __________________________SSN:_____________________________

Employer: ____ Work #: ( ) ___________________ Home # :( )___________________

Billing Address: ____ Cell #: ( ) ___________________________

INSURANCE INFORMATION

Primary Ins: ______________________________ Ins. Co. Ph #: ( ) ________________Group #:___________ ID#:_____________________

Subscriber Name: ____________________________Relation: _________________Subscriber Birthdate: ___/____/___ SS#____________________

Subscriber's Employer: ____ Subscriber's Phone #: ( ) ________________________

Sec. Ins: ______________________________ Ins. Co. Ph #: ( ) _______________Group #:___________ ID#:________________________

Subscriber Name: ____________________________Relation: ________________ Subscriber Birthdate: ____/____/___ SS#____________________

Subscriber's Employer: ____ Subscriber's Phone # :( )________________________

AUTHORIZATIONS

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental team to perform the necessary dental services I may need.

My method of payment will be ______________________________________.

____________________________________ ____________________
SIGNATURE DATE

PAYMENT IS DUE AT TIME OF SERVICE

I certify that I am covered by ______________________ insurance Co.

and I assign directly to **Greg Stafford, DDS, PA** all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic

____________________________________ ____________________
SIGNATURE DATE

Our office is HIPAA compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, CDC & ADA

HISTORY

Why have you come today? ____

____

Are you currently in pain? ☐ Y ☐ N

Do you require antibiotics before dental treatments? ☐ Y ☐ N

Any complications from previous dental treatment? ☐ Y ☐ N

Have you been treated for gum disease in the past? ☐ Y ☐ N

Have you had a traumatic dental experience? ☐ Y ☐ N

Are there any specific concerns you would like addressed by your Dental Hygienist or Dentist? ____

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____

Do you have any specific questions for your Dental Hygienist or Dentist?

____

____

What are your concerns today? Circle all that apply

Cavities	Crooked teeth	Swelling
Gum Disease/bleeding	Poor fitting denture	Whiter teeth
Jaw/Joint Problems	Wisdom tooth issue	Tooth discoloration
Bad Breath	Broken teeth	Missing teeth
Tooth sensitivity	Dry mouth	Tooth injury
Grinding teeth	Tooth pain	Broken filling

What is the date of your last dental visit :_____________________________________

Date of your last dental x-rays: _____________ Date of last cleaning:______________

Are you happy with the way your smile looks? If not, what would you change?

____

____

Do you have a personal physician? ☐ Y ☐ N

Physician's Name:____

Phone#:( ) __________________ Date of last visit: _________________

Are you currently under the care of a physician? ☐ Y ☐ N

Please explain: ____

Have you been hospitalized or had surgery? ☐ Y ☐ N

Have you been treated for cancer? ☐ Y ☐ N

Have you had an organ transplant? ☐ Y ☐ N

Do you drink more than two alcoholic beverages per day? ☐ Y ☐ N

Do you smoke or use tobacco? ☐ Y ☐ N

Are you allergic to any of the following?

Y N Acrylics/Plastics	Y N Codeine	Y N Latex
Y N Aspirin	Y N Hydrocodone	Y N Novocaine/Lidocaine
Y N Penicillin	Y N Jewelry/Metals	Y N Tylenol
Y N Clindamycin	Y N Keflex	Y N Other

Please list additional drugs/materials that cause allergic reactions:

____

Are you taking birth control pills? ☐ Y ☐ N

Are you pregnant? ☐ Unsure ☐ Yes ☐ No Week#____________

Are you nursing? ☐ Y ☐ N

Are you taking any of the following?

Y N Acetaminophen	Y N Blood Thinners	Y N Nitroglycerin
Y N Antibiotics	Y N Blood Pressure medication	Y N Steroids/Cortisone
Y N Antihistamines	Y N Digitalis / Heart medication	Y N Thyroid Medicine
Y N Aspirin	Y N Insulin / Diabetes drugs	Y N Tranquilizers

Have you ever taken Bisphosphonates for bone density? ☐ Y ☐ N

Are you currently taking any prescription, over-the-counter drugs, herbal remedies, vitamins, minerals, or recreational drugs? If yes, please list each one below.

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Circle if you have ever had any of the following diseases or medical problems

Anxiety	Cerebral Palsy	Drug dependency or abuse	High blood pressure	Osteoporosis
Anemia	Chest pains or angina	Emphysema	High cholesterol	Pacemaker or defibrillator
Artificial heart valve	Chronic bronchitis	Epilepsy	HIV	Paralysis
Artificial joints	Chronic constipation	Fainting	Indigestion	Persistent cough
Arthritis	Chronic diarrhea	Gallstones	Kidney failure	Pneumonia
Asthma	Colitis	Glaucoma	Liver disease	PTSD
Autoimmune disorder	COPD	Hand/wrist pain	Low blood pressure	Renal dialysis
Bleeding disorder	Congestive Heart Failure	Heart arrhythmia	Low blood sugar	Sinus problems
Blood clots	Crohn's disease	Heart attack	Migraine headaches	Sjorgren's syndrome
Bulimia	Cystic Fibrosis	Heartburn	Mitral Valve Prolapse	Stroke
Cardiac stents	Depression	Herpes/cold sores	Multiple sclerosis	Tuberculosis
Carpal tunnel syndrome	Diabetes	Hepatitis	Neck pain	Vision impairment

Dental Appointment Agreement

1. Cancellation/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly “full” appointment book. **If an appointment is not canceled at least one business day in advance you will be charged a $50.00 fee; this will not be covered by your insurance company.**

2. Scheduled Appointments

We understand that delays can happen, however, we must try to keep the other patients and doctors on time. **If you arrive late to your scheduled appointment, then the appointment may have to be rescheduled if there is not enough time to complete your procedure.**

If you have any questions regarding this policy, please let our team know and we will be glad to clarify any questions you have.

We value for your patronage. This policy helps our office to provide the best services possible for all of our patients.

I have read and understand the Appointment Cancellation Policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

I, ___________________________ (print name), have reviewed the Downtown Dental Care Appointment Policy.

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Signature of patient/ Guardian of patient Date