Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Welcome to our Practice

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ Last _____ First _____ MI _____ Preferred Name

Title: _____ Mr/Ms/Mrs/etc Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ SS #. _____ Prev. Visit: _____

Email Address: _____ Best time to call: _____

Phone: _____ Home _____ Work _____ Ext _____ Mobile _____ Fax _____ Other

Address: _____ _____
_____ City _____ State _____ Zip Code

Please enter Employer and Occupation

_____

Whom may we thank for referring you to our practice?

_____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Responsible Party Information:

This ONLY needs to be filled out if the patient is under 18 years.

The following is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ neither-not applicable

Name: _____ _____ ____ _____
Last First MI Preferred Name

Title: _____ Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ SS #. _____ Driver's License #: _____

Email Address: _____ Best time to call: _____

Phone: _____ _____ ____ _____ _____ _____
Home Work Ext Mobile Fax Other

Address: _____ _____
_____ ____ _____
City State Zip Code

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____
_____ ____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
_____ ____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
_____ ____ _____
City State Zip Code

Insurance Company Phone Number:

_____

Insurance Authorization:

☐ By checking this box,
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous Dentist and reason for leaving:

Date of most recent dental exam and dental x-rays:

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is the reason for your visit today?

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Have dry mouth
- ☐ Food gets trapped between any teeth
- ☐ Would you like your teeth whiter
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance
- ☐ Have been treated for gum disease
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Snore or wake up frequently during the night
- ☐ Had trouble getting numb
- ☐ Had or have braces (orthodontic treatment)
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Have whitened or bleached your teeth
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Clench or grind your teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Have or had gum recession
- ☐ Have or had a burning sensation in your mouth
- ☐ Would like to change the appearance of my smile

If any of the checked boxes need further explanation, please describe:

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Medical History

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

- ☐ *MedList DocCenter
- ☐ *Pat in Wheelchair
- ☐ *Pre-Med - Amox
- ☐ *Pre-Med - Clind
- ☐ *Pre-Med - Keflex
- ☐ *Pre-Med - Other
- ☐ *Pre-Med -Cepahlexin
- ☐ *Pre-Med -Cephalexin
- ☐ Allergy - Amoxicilli
- ☐ Allergy - Aspirin
- ☐ Allergy - Cephalexin
- ☐ Allergy - Codeine
- ☐ Allergy - Diazepan
- ☐ Allergy - Erythro
- ☐ Allergy - Fluoride
- ☐ Allergy - Ibuprophen
- ☐ Allergy - Iodine
- ☐ Allergy - Latex
- ☐ Allergy - Penicillin
- ☐ Allergy - Percocet
- ☐ Allergy - Sulfa
- ☐ Allergy-Macrodantin
- ☐ Allergy-Tetracyclin
- ☐ Allery - Tylenol
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Boniva/Fosamax/Acton
- ☐ Cancer
- ☐ Cleft Palet
- ☐ Diabetes Type I
- ☐ Diabetes Type II
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fibromyalgia
- ☐ Glaucoma
- ☐ Head Injuries
- ☐ Heart Condition
- ☐ Heart Murmur
- ☐ Hepatitis "C"
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ MVP
- ☐ Nervous Disorders
- ☐ No Epi
- ☐ Other
- ☐ Pacemaker
- ☐ Pat Takes Aspirin
- ☐ Pregnancy
- ☐ Pre-Med Valium/Zanax
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ SeeMedHistory
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sjorgren's Syndrom
- ☐ Stents
- ☐ TMJ
- ☐ Tuberculosis

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

- [ ] Valve Replacement
- [ ] Venereal Disease
- [ ] Vertigo-Sit up

- [ ] Ever been hospitalized (illness or injury)
- [ ] Presently being treated for any other illnesses
- [ ] Subject to frequent headaches
- [ ] Tobacco/Alcohol Use
- [ ] FEMALE: Taking birth control pills
- [ ] FEMALE: Pregnant

If any conditions or alerts selected above need further clarification, please describe below:

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Do you take antibiotic premedication for your dental visits?

* ◯ Yes ◯ No

If yes, please explain in the box provded below:

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Name of your physician and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

List all medications (prescription and non-prescription) including regular doses of aspirin:

* ☐ By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the AdministrationForm.

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

HIPAA Acknowledgement

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 healthcare 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 re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

* ☐ By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.

Craig A. Sterling, DMD, PA
9121 North Military Trail
Suite #220
Palm Beach Gardens FL
(561)626-5119
sterlingtooth@gmail.com

Consent for Internet Communications

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

* ☐ I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site. This will serve as my electronic signature.

Name of person filling out this form:

* _____

Relationship to patient:

* ☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent
☐ Legal Guardian ☐ Other

Response Date: _____