Craig A. Sterling, DMD, PA

9121 North Military Trail | Suite #220 • Palm Beach Gardens, FL 33410 (561)626-5119

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) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Whom may we thank for referring you to our practice?

_____

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

Emergency Contact:

_____

_____

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) ____-____ (Zip Code)

Responsible Party/ Spouse Information:

This only needs to be completed if the insurance subscriber is someone other than the patient, or your are the parent/guardian of the patient.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ 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#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

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

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

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

Insurance Plan Name: _____

Subscriber ID _____

Subscriber D.O.B. _____

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.

Dental Information

What is your immediate concern?

_____

_____

Previous Dentist Name and Phone Number:

_____

_____

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

_____

_____

Is there anything about the appearance of your smile that you would like to change?

_____

_____

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had trouble getting numb
- ☐ Had any reactions to local anesthetic
- ☐ Had/have braces, orthodontic treatment
- ☐ You experience dry mouth
- ☐ Any teeth sensitive to hot, cold, biting, sweets or avoid brushing any part of your mouth
- ☐ Food gets trapped between any teeth
- ☐ Have you ever whitened or bleached your teeth
- ☐ Have you experienced popping and/or clicking of your jaw joint
- ☐ You have difficulty chewing
- ☐ You clench or grind your teeth
- ☐ You wear or have worn a bite appliance
- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury)
- ☐ Experienced a burning sensation in your mouth
- ☐ You snore or wake up frequently during the night

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

_____

_____

_____

_____

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 Administration Form.

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 allow this practice to disclose my Protective Health Information to the following individuals: (This information could include: Name, Diagnosis, Test Results, Images and Account Information.)

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.

Please bring dental insurance card(s) with you to your appointment.

Response Date: _____

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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.

- ☐ *Pat in Wheelchair
- ☐ ADHD
- ☐ Allergy - Amoxicilli
- ☐ Allergy - Chlorahexa
- ☐ Allergy - Ibuprophen
- ☐ Allergy - Nuts
- ☐ Allergy - Topical
- ☐ Allery - Tylenol
- ☐ Anxiety
- ☐ Auto immune disease
- ☐ Blood clot
- ☐ Cleft Palet
- ☐ Diabetes Type II
- ☐ Excessive Bleeding
- ☐ HPV
- ☐ Heart Murmur
- ☐ IBS
- ☐ Multiple Sclerosis
- ☐ Other
- ☐ Rheumatic Fever
- ☐ Stents
- ☐ Tuberculosis
- ☐ *Pre-Med - Amox
- ☐ AFIB
- ☐ Allergy - Aspirin
- ☐ Allergy - Codeine
- ☐ Allergy - Iodine
- ☐ Allergy - Penicillin
- ☐ Allergy -Clindamycin
- ☐ Alzheimers disease
- ☐ Arthritis
- ☐ Bi-Polar
- ☐ COPD
- ☐ Dementia
- ☐ Emphysema
- ☐ Fibromyalgia
- ☐ Hashimotos
- ☐ Hepatitis
- ☐ Lupus
- ☐ No Local/ Epi
- ☐ Pacemaker
- ☐ SeeMedHistory
- ☐ Stroke
- ☐ Valve Replacement
- ☐ *Pre-Med - Clind
- ☐ Acid Reflux
- ☐ Allergy - Augmentin
- ☐ Allergy - Erythro
- ☐ Allergy - Latex
- ☐ Allergy - Percocet
- ☐ Allergy Fluoridex
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Epilepsy
- ☐ Grave's Disease
- ☐ Head Injuries
- ☐ Hepatitis "C"
- ☐ Migraines
- ☐ Non Hodgkin's Lympho
- ☐ Parkinsons
- ☐ Seizures
- ☐ TMJ
- ☐ Venereal Disease
- ☐ *Pre-Med - Other
- ☐ Alcohol Use
- ☐ Allergy - Bactrim
- ☐ Allergy - Fluoride
- ☐ Allergy - Novocaine
- ☐ Allergy - Sulfa
- ☐ Allergy- Local Anest
- ☐ Angina
- ☐ Asthma
- ☐ Blood Thinners
- ☐ Cerebral Palsy
- ☐ Diabetes Type I
- ☐ Essential Tremor
- ☐ HIV
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Mitral Valve Prolaps
- ☐ Osteoporosis
- ☐ Radiation Treatment
- ☐ Sinus Problems
- ☐ Thyroid Trouble
- ☐ Vertigo

☐ Ever been hospitalized (illness or injury) ☐ Subject to frequent headaches ☐ FEMALE: Taking birth control pills
☐ FEMALE: Pregnant

Please explain/clarify any conditions or alerts selected above:

Conditions/Alerts:

_____
_____
_____
_____

Allergies not listed:

_____
_____

Do you use tobacco (smoke and/or smokeless)? * ◯ Yes ◯ No

If yes, please explain:

Do you take antibiotic premedication for your dental visits? If yes, please explain below: * ◯ Yes ◯ No

Pre-Med:

Name of your Physician and Phone Number:

Preferred Pharmacy and Phone Number:

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

Are you currently taking any medications (prescription and non-prescription) including regular doses of aspirin? If yes, please list all medications and dosages below: *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

☐ ***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.**

THE FOLLOWING SECTION IS FOR EXISTING PATIENTS ONLY

Please review and update the following information if needed. Thank you.

Chart#: _____
FOR OFFICE USE ONLY

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

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

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Primary Dental Insurance

Name of Insured: _____ _____ ___
Last First MI

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

Insurance Plan Name: _____

If your dental insurance has changed, please bring your card with you to your appointment.

Response Date: _____

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Patient Screening Form

Please complete the following form.

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

Do you have fever or have you felt hot or feverish recently (14-21 days)? * ◯ Yes ◯ No

Are you having shortness of breath or other difficulties breathing? * ◯ Yes ◯ No

Do you have a cough? * ◯ Yes ◯ No

Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue? * ◯ Yes ◯ No

Are you in contact with any confirmed COVID-19 positive patients?
***Patients who are well but have a sick family member at home with COVID-19 should consider postponing elective treatment. ***
◯ Yes ◯ No

Response Date: _____