Welcome

We are pleased to welcome you to our practice. Whether you are visiting our office for the first time, or are an existing patient, please take a few minutes to fill out this form as completely as you can. We look forward to working with you in maintaining your dental health.

Patient Information

Name:_____ **SS#**_____

Address:_____

City:_____ **State:**_____ **Zip:**_____

Mailing address:_____

Hm Phone:_____ **Wk Phone:**_____

Cell#:_____ **DOB:**_____ **Age:**_____

Sex: Male ☐ Female ☐ / ☐ Married ☐ Single ☐ Child

Employer:_____ **Occupation:**_____

Whom may we thank for referring you?_____

Primary Insurance Company

Insurance company:_____

Address:_____

Phone:_____ **Group#:**_____

I.D.#:_____ **Insured Name:**_____

DOB:_____ **SS#:**_____ **Relationship to Pt:**_____

Secondary Insurance Company

Insurance Company:_____

Address:_____

Phone:_____ **Group#**_____

I.D.#:_____ **Insured Name:**_____

DOB:_____ **SS#:**_____ **Relationship to Pt:**_____

MEDICAL HISTORY

Name:_____ **DOB:**_____ **Age:**_____

E-MAIL_____

Hm Phone#_____ **Work#**_____ **Cell#**_____
Best way to confirm your appointments Hm# Text E-mail
(please circle one)

Address_____ **City**_____ **Zip**_____

Physicians Name:_____ **Phone:**_____

Emergency Contact:_____ **Phone:**_____

Please indicate if you have had or currently have any of the following health problems

- ☐ **Stroke**
- ☐ **Diabetes/Hypoglycemia**
- ☐ **High/Low Blood Pressure**
- ☐ **Tuberculosis**
- ☐ **Mitral Valve Prolapse**
- ☐ **HIV / AIDS**
- ☐ **Heart Attack**
- ☐ **Rheumatic Fever**
- ☐ **Alcoholism/Drugs**
- ☐ **Hemophilia**
- ☐ **Currently Pregnant**_____ **mos**
- ☐ **Scarlet Fever**
- ☐ **Heart Murmur**
- ☐ **Asthma** ☐ **Allergies**
- ☐ **Hepatitis- A, B, C**
- ☐ **Artificial Heart Valve(s) Date:**_____
- ☐ **Cancer Type:**_____ **Date:**_____
- ☐ **Joint Replacement Date:**_____
- ☐ **Stent (s) Date placed**_____
- ☐ **Other:**_____

Do you require Pre-Medication for dental treatment Y N
(Antibiotics only) (Please circle one)

Are you allergic to any of the following Medications?

☐ **Penicillin/Amoxicillin** ☐ **Aspirin** ☐ **Dental Anesthetics**

☐ **Codeine** ☐ **Latex** ☐ **Erythromycin** ☐ **Tetracycline** ☐ **Sulfa**

Other(s):_____

Please list any medications you are currently taking: _____

_____ _____ _____

_____ _____ _____

Date of last physical:

The medical information above was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to my medical history.

Patient/Guardian Signature_____ Date_____

Updated_____ Date_____

FINANCIAL POLICY FOR THE OFFICE OF DAN L. STAMBAUGH D.M.D

PAYMENTS:

Payment is due at the time services are rendered. For your convenience, we accept cash, checks, Visa, MasterCard, and American Express. Our Financial Coordinator will discuss with you the fees for your recommended treatment and an estimate of the insurance's payment.

INSURANCE:

As a courtesy, our office will bill your insurance if we receive the necessary information. We make every attempt to accurately estimate what your insurance will pay; however determining your benefits is based on your insurance company's policy, exclusions, and fee schedule. We strongly encourage each patient to review their benefits booklet. Pre-authorizations for treatment sent to your insurance is not a guarantee of benefits or payment but an estimate only. Insurance is a contract between you and your insurance company. We are not party to this contract, in most cases. You agree to pay any portion of the charges not covered by insurance. This includes your deductible and all co-pays at the time of service.

If your account becomes past due, we will take the necessary steps to collect this debt. If we have to refer your account to a collection agency, your account becomes inactive. You must contact the agency in order to pay the balance. Accounts that become 60 days past due are subject to a finance charge at the rate of 1.5% per month (18%) annually or a $0.50 minimum charge. All appointments will be canceled until the account is current. This includes accounts with insurance as well. You will need to contact your insurance company for any information pertaining to "no payment" on your account. We will be happy to assist you on this and re-submit any claims necessary. All payments are due by the 20th of each month.. Late payments are subject to a $25.00 late fee.

PAST DUE ACCOUNTS:

ADDITIONAL FEES:

The second time a patient does not show up for their scheduled appointment, or cancels with less than a 24 hour notice, is subject to a $50.00 fee. This must be paid before a new appointment is scheduled. There is a $25.00 returned check fee for any checks returned by the bank. If you request copies of your records to be sent to another doctor, a $25.00 copying fee for x-rays is charged and a release of records form needs to be signed. A third missed appointment or late cancel, our office reserves the right to release the patient from the practice.

I have read and agree to the above financial policy and understand that by signing this form the terms and conditions contained herein are in effect.

*Signature:*_____ *Date:*_____

Dan L. Stambaugh D.M.D., P.C.

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ACKNOWLEDGMENT AND CONSENT FOR DISCLOSURE OF HEALTH INFORMATION AND PRIVACY PRACTICES

**** You May Refuse to Sign This Acknowledgment****

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy practices before you decide to sign this consent. We will be happy to give you one.

_____ _____

(Signature) (Date)

If consent is signed by a guardian, parent, or representative on behalf of the patient, please complete the following:

Personal Representative's Name_____

Relationship to Patient_____

Dan L. Stambaugh, DMD, PC
1863 Laura Street
Springfield, OR 97477
(541) 746-4417

Date:_____

I, _____, authorize Dr. Stambaugh's office to request copies of all necessary and current x-rays/dental records. I understand these records will be used for the purpose of diagnosing and providing dental services only after I have given my consent to perform such treatment. All personal information will be maintained in accordance with current HIPAA requirements.

Please send these documents to:

Dan L. Stambaugh, DMD, PC
1863 Laura Street
Springfield, OR 97477
(541) 746-4417
Fax (541) 746-4419

Email address: anna@drdanstambaugh.com

Signature:_____Date:_____

Please forward via email

- Panorex or FMX
- BWX
- Perio Chart

Please include dates