D. SCOTT STAYNER, D.D.S.

Thank you for choosing our office! In order to serve you properly, we need the following information.
Please print. All information will be confidential.

Date _____ Patient Name _____ Birthday _____ ❒ M ❒ F
FIRST MI LAST

SSN _____ Hm ph. _____ / Cell _____ / Email _____

Address _____ City _____ State _____ Zip _____

Check appropriate box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated

Emergency contact: Name _____ Ph: _____

RESPONSIBLE PARTY

Name of person responsible for this account _____ Relationship to patient _____
Address _____
Driver's license _____ Birthdate _____ Home phone _____
Employer _____ Work phone _____
Is this person currently a patient at our office? ❒ Yes ❒ No
Check appropriate box: ❒ Minor ❒ Single ❒ Married ❒ Divorced ❒ Widowed ❒ Separated
Spouse's name _____ Social Security Number _____
Address _____
Driver's license _____ Birthdate _____ Home Phone _____
Employer _____ Work Phone _____
Is this person currently a patient at our office? ❒ Yes ❒ No

INSURANCE INFORMATION

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security Number _____ Date Employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group _____ Union or local _____
Ins. Co. address _____ City _____ State _____ Zip _____

SECONDARY INSURANCE

Name of insured _____ Relationship to patient _____
Birthdate _____ Social Security Number _____ Date employed _____
Name of employer _____ Work phone _____
Address of employer _____ City _____ State _____ Zip _____
Insurance company _____ Group _____ Union or local _____
Ins. Co. address _____ City _____ State _____ Zip _____
Previous dentist and address _____
How did you hear about our office? _____

I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor.

X _____ _____
Signature of patient or parent if minor Date

I understand that if my account is not paid within 90 days of service, it will be subject to a finance charge.

OVER

PLEASE CIRCLE THE CORRECT RESPONSE:

Are your teeth affecting your general health? ..... Yes No
Are any of your teeth causing you problems? ..... Yes No
Have you noticed any swelling or lumps in your mouth? ..... Yes No
Do your gums bleed easily? ..... Yes No
Do you have a dry mouth? ..... Yes No
Do you experience jaw clicking, popping, or pain? ..... Yes No
Have you ever had cold sores, canker sores, or fever blisters? ..... Yes No
Do you clench or grind your teeth? ..... Yes No
Have you been treated for gum (periodontal) disease? ..... Yes No
Do you brush twice a day? ..... Yes No
Do you use dental floss daily? ..... Yes No
When was your last dental exam and cleaning? ..... Yes No

PLEASE CIRCLE THE CORRECT RESPONSE:

AIDS, HIV, ARC Syndrome ..... Yes No
Alcoholism ..... Yes No
Allergies/Hay fever ..... Yes No
Anemia ..... Yes No
Arteriosclerosis ..... Yes No
Arthritis ..... Yes No
Asthma ..... Yes No
Chest Pains ..... Yes No
Codeine (Allergy) ..... Yes No
Dental Anesthetic (Allergy) ..... Yes No
Diabetes ..... Yes No
Emotional Problems ..... Yes No
Epilepsy or Seizures ..... Yes No
Excessive Swollen Ankles ..... Yes No
Heart Murmur ..... Yes No
Heart Trouble ..... Yes No
Hepatitis ..... Yes No

Herpes/Venereal Disease ..... Yes No
High Blood Pressure ..... Yes No
Kidney Disease ..... Yes No
Liver Disease ..... Yes No
Low Blood Pressure ..... Yes No
Penicillin or Antibiotics (Allergy) ..... Yes No
Prolonged Bleeding ..... Yes No
Prosthetic Joint/pins/screws/plates ..... Yes No
Prosthetic Valve ..... Yes No
Radiation Treatment ..... Yes No
Rheumatic Fever ..... Yes No
Shortness of Breath ..... Yes No
Stroke ..... Yes No
Thyroid Disorders ..... Yes No
Tuberculosis ..... Yes No
Tumor or Abnormal Growth ..... Yes No
Eating Disorders ..... Yes No

Allergy to other medications ..... Yes No Please List: _____

Any other areas of concern or past medical problems? ..... Yes No

Please explain: _____

ARE YOU:

Aware of any changes in your general health? ..... Yes No
Presently being treated for any illness? ..... Yes No
Smoking? ..... Yes No
Using smokeless tobacco? ..... Yes No
Taking any medications or dietary/herbal supplements regularly ..... Yes No
What medications? _____
For what purpose? _____

FEMALES:

Is there any possibility of pregnancy? ..... Yes No
Are you taking oral contraceptives? ..... Yes No

Signature of patient (parent if minor) _____ Date _____