Stansell Dentistry Associates

New Patient Registration

First Name:
Last Name:
Prefers to be called:
Date of birth:
Cell number:
Home number:
Work Number:
Address:
City:
State:
Zip Code:
Email:
Social Security Number:
Emergency Contact, Name/Number:
How did you hear about us? (circle) Yelp Angies List Google Friend/Family Other ____________________

Dental Insurance

Insurance Company:
Policy ID number or Social security number:
Insurance company's phone number:
Insured's name:
Insured's date of birth:
Insured's employer:

Stansell Dentistry Associates

Although dental personnel primarily treat the area in and around your mouth, your mouth is a pan of your entire body. Health problems that you may have or medication that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions;

Are you under a physician's care now? Yes No If yes, please explain____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain_________________________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain____

Do you take or have you taken Phen-Fen or Redux? Yes No If yes, please explain_______________________________________

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women are you
Pregnant/Trying to get Pregnant? Yes No Taking Oral Contraceptives? Yes No Nursing? Yes No

Are you allergic to the following:
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other? If yes please explain: ____

Do you have or have you had any of the following?

AIDS/HIV Positive:	Yes	No	Cortisone Medicine:	Yes	No	Hemophilia:	Yes	No	Renal Dialysis:	Yes	No
Alzheimer's Disease:	Yes	No	Diabetes:	Yes	No	Hepatitis A:	Yes	No	Rheumatic Fever:	Yes	No
Anaphylaxis:	Yes	No	Drug Addiction:	Yes	No	Hepatitis B or C:	Yes	No	Rheumatism:	Yes	No
Anemia:	Yes	No	Easily Winded:	Yes	No	Herpes:	Yes	No	Scarlet Fever:	Yes	No
Angina:	Yes	No	Emphysema:	Yes	No	High Blood Pressure:	Yes	No	Shingles:	Yes	No
Arthritis/Gout:	Yes	No	Epilepsy or Seizures:	Yes	No	High Cholesterol:	Yes	No	Sickle Cell Disease:	Yes	No
Artificial Heart Valve:	Yes	No	Excessive Bleeding:	Yes	No	Hives or Rash:	Yes	No	Sinus Trouble:	Yes	No
Artificial Joint:	Yes	No	Excessive Thirst:	Yes	No	Hypoglycemia:	Yes	No	Spina Bifida:	Yes	No
Asthma:	Yes	No	Fainting Spells/Dizziness:	Yes	No	Irregular Heartbeat:	Yes	No	Stomach/Intestinal Disease:	Yes	No
Blood Disease:	Yes	No	Frequent Cough:	Yes	No	Kidney Problems:	Yes	No	Stroke:	Yes	No
Blood Transfusion:	Yes	No	Frequent Diarrhea:	Yes	No	Leukemia:	Yes	No	Swelling of Limbs:	Yes	No
Breathing Problems:	Yes	No	Frequent Headaches:	Yes	No	Liver Disease:	Yes	No	Thyroid Disease:	Yes	No
Bruise Easily:	Yes	No	Genital Herpes:	Yes	No	Low Blood Pressure:	Yes	No	Tonsillitis:	Yes	No
Cancer:	Yes	No	Glaucoma:	Yes	No	Lung Disease:	Yes	No	Tuberculosis:	Yes	No
Chemotherapy:	Yes	No	Hay Fever:	Yes	No	Mitral Valve Prolapse:	Yes	No	Tumors of Growths:	Yes	No
Chest Pains:	Yes	No	Heart Attack/Failure:	Yes	No	Osteoporosis:	Yes	No	Ulcers:	Yes	No
Cold Sores/Fever Blisters:	Yes	No	Heart Murmur:	Yes	No	Pain in Jaw Joints:	Yes	No	Venereal Disease:	Yes	No
Congenital Heart Disorder:	Yes	No	Heart Pacemaker:	Yes	No	Parathyroid Disease:	Yes	No	Yellow Jaundice:	Yes	No
Convulsions:	Yes	No	Heart Trouble/Disease:	Yes	No	Psychiatric Care:	Yes	No			

Have you ever had a serious illness not listed:____
Comments: ____
____

To my best knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dentist office of any changes in medical status.

____

Signature of patient, parent, or guardian ____________________________________ Date ______________________

Dental Questionnaire

My Dental Goals are: (please circle all that apply)

Pain Free	Full Dentures	Hollywood Smile
Whiter Teeth	Cavity Free	Partials
Straighter Teeth	Better Breath	Better Chewing
Healthier Gums	Less Bleeding	Decrease Sensitivity
Stop Smoking	Sedation Dentistry	Replace Missing Teeth

How long has it been since you have been to the dentist: ____

When was the last time your teeth were cleaned:____

May we take Dental x-rays: (circle) YES NO

If you are female, is there any chance of pregnancy: (circle) YES NO

Do you clench or grind your teeth: (circle) YES NO

Do you take fluoride supplements: (circle) YES NO

Have you ever had periodontal Treatment (gum disease): (circle) YES NO

Have you ever had orthodontic treatment (braces): (circle) YES NO

Do you floss regularly: (circle) YES NO

Do your gums bleed when you brush or floss: (circle) YES NO

Have you ever been concerned about bad breath: (circle) YES NO

Do you consistently get a bad taste in your mouth: (circle) YES NO

Do you use mouth rinse: (circle) YES NO

Have you ever experienced unusual reaction to dental anesthetic: (circle) YES NO

If the doctor or staff member suffers a needlestick or puncture wound, will you consent to a blood test per OSHA regulations (at our expense): (circle) YES NO

General Dental Informed Consent Form

Dr. Stansell would like all of her patients to have knowledge risks and benefits of dental procedures. We ask that you review the procedures listed and feel free to ask anu questions. A treatment plan for all restorative work, which includes **estimated** fees and treatment specific authorization, will be presented to you for your review and signature at the time treatment is recommended.

1. **Drugs and Medication**: Antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Risk of local anesthesia may include temporary or permanent numbness or brushing. If you are taking oral contraceptives, use of antibiotics can lessen the effectiveness thereby putting you at risk of pregnancy.
2. **Changes in Treatment**: During treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures.
3. **Removal of Teeth**: Alternatives will be explained to you (root canal therapy, crowns, and periodontal surgery, etc). The removal of teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. Some of the risks are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue, and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. Further treatment by a specialist or even hospitalization if complications arise during or following treatment would be your responsibility.
4. **Crowns and Bridges**: Sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. You may wear temporary crowns, which may come off easily. You will need to be careful to ensure that they are kept on until the permanent crowns are delivered. The final opportunity to make changes to a new crown or bridge (including shape, fit, size, or color) must be done at the preparation appointment.
5. **Partials**: They are artificial, constructed of acrylic, metal and/or porcelain. The problem of wearing these appliances includes looseness, soreness, and possible breakage. Most partials require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial fee.
6. **Endodontic Treatment (Root Canal)**: There is no guarantee that root canal treatment will save a tooth. Complications can occur from treatment and occasionally metal objects are cemented in the tooth or extended through the root. Which does not necessarily affect the success of the treatment. Occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
7. **Periodontal Loss (Tissue & Bone)**: This is a serious condition, causing gum and bone infection or loss and can lead to the loss of teeth. Alternative treatment will be explained to you (gum surgery, replacements, and/or extractions). Any dental procedure may have future adverse effect on your periodontal condition.
8. **Implants**: They are permanent alternative to bridges, partials, or dentures. This process involves several steps and could last from 2-6 months before complete (depending on healing time needed). As with crowns, color may not match perfectly with natural teeth.
9. **Sealants**: there is no guarantee that a sealant will prevent all cavities. They do, however, form a hard shield that keeps food and bacteria from getting into tiny grooves and causing decay along the chewing surfaces of the back teeth. Occasionally sealants need to be replaced, since they do not last a lifetime. We do, however, warranty our sealants for 2 years as long as the patient is seen twice a year for prophylaxis visits. Sealants can be done at any age as long as the teeth are free of decay and fillings. The doctor will determine the best time to have it done.
10. **Sedative fillings and Temporary Crowns**: Sedative fillings are temporary. If the tooth is asymptomatic after 4-6 weeks, then the root has not been exposed. The sedative filling allows the tooth to lay down reparative dentin and will enable the Doctor to remove the decay and restore the tooth. Avoid eating/chewing on those teeth as much as possible to avoid breakage. Call the office if they come out or break to have them replaced.
11. **Fillings**: There is a risk of sensitivity and/or soreness after replacement of fillings. The life of fillings is prolonged with daily oral care including but not limited to, flossing and brushing. I understand that any time a restoration is performed there is a possibility of trauma to the nerve of the tooth, which could result in varying degrees of sensitivity and complications including but not limited to the following: cold sensitivity, hot sensitivity, biting sensitivity, abscess, and pulp necrosis. Most of the symptoms usually resolve as the nerve heals. Complications may arise resulting in the need for additional treatment. This may include one or more bite adjustments, replacement of the restoration due to open margins discovered after final cementation, root canal treatment or tooth removal

I have carefully read above informed consent and fully understand all risks as it relates to my case.

Patient Signature____

Date ____

Stansell Dentistry Financial Policy and Agreement

Thank you for choosing Stansell Dentistry for your dental needs. We are committed to providing our patients with excellent care and convenient financial arrangements. Our financial arrangements are based on recommended treatment plans, respective fees, and patients financial capabilities.

To confirm your understanding and agreement with our policies, please read the following:

Payment:
Payment in full is due at the time of service unless prior financial arrangements are made. For your convenience, we offer several forms of payment options.

1. Cash, check, Visa, Mastercard, AMEX, and Discover.
2. CareCredit Financing.

Insurance:
Our office is committed to helping patients maximize their benefits. Insurance policies vary greatly. Therefore, owing to the complexity of insurance contracts, we can only estimate in good faith, not guarantee coverage. Your estimated patient portion must be paid at the time service is delivered. As a service to our patients, we will bill your insurance company for service, and allow 60 days for them to render payment. After 90 days, you are responsible for the entire balance and it will be due in full. If you have any questions, our courteous staff is always available to answer them.

Minors:
Payment for services for treatment of minors is the responsibility of the adult accompanying the minor.

Missed Appointments:
Your appointment time has been specially reserved for you. We reserve the right to charge $25 per hour cancellation fee for all cancelled or missed appointments without 24 hour notice.

Speciality Services:
All one appointment treatment plans over $500 require a 50% nonrefundable deposit at time of scheduling appointment and will not be refunded if the patient fails to show for appointment or if cancelled within 48 hours of the appointment.

Service Charges:
For any past due accounts over 90 days a 5% monthly interest charge (24% annual charge) will be applied. We will charge $40 for a returned check.

Collection Fees:
Fees incurred to collect payment will be billed to and payable by the patient's account holder.

Financial Consent:
The patient (account holder) agrees to be fully responsible for total payment of treatment performed in the office.

Scheduling:
We strive to be on time with our schedule, therefore when patients are more than 15 minutes late we will be unable to see them that day. Once patients are more than 15 minutes late we will call to reschedule the appointment.

I understand and agree to this Financial Policy and Agreement

____

Signature of Patient/Responsible Party Date

Authorization for Release of Information

Name of Patient ____ Date of Birth ______________

Stansell Dentistry Associates is authorized to release protected health information about the above named patient in the following manner and to identified persons.

Entity to Receive Information. Check each person/entity that you approve to receive information.	**Description of information to be released.** Check each that can be given to person/entity on the left in the same section.
☐ Voice Mail ☐ Text	☐ Results of lab tests/x-rays ☐ Financial
☐ Other (provide name below) _______________________________________ _______________________________________	☐ Medical ☐ Appointment reminders
☐ Email communication-Provide email address* _________________________________ *For email and text communication to occur, please accept the disclosure below:	
☐ For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
☐ Photo of patient received by patient or legal guardian ☐ Photo taken by staff (Example: pre/post procedure) ☐ May be posted in office	☐ May be posted on website ☐ Other________________________________

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

____Date ____________________

Signature of Patient or Personal Representative

*Description of Personal Representative's Authority (attach necessary documentation)

Stansell Dentistry Associates
Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. Effective date: April 14, 2003. Revised: May 22, 2017

If you have any questions about this Notice please contact the Privacy Officer: Jessica Parry

The privacy of your health is important to us.

We are committed to protect the privacy of your personal health information (PHI).

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations. We may also share your information for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI.

We are required by law to maintain the privacy of your PHI. We will follow the terms outlined in this Notice.

We may change our Notice, at any time. Any changes will apply to all PHI. Upon your request, we will provide you with any revised Notice by:

- Posting the new Notice in our office.
- If requested, making copies of the new Notice available in our office or by mail.
- Posting the revised Notice on our website: **www.Stanselldentistry.com**

Uses and Disclosures of Protected Health Information

We may use or disclose (share) your PHI to provide healthcare treatment for you.

Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you.

For example, your PHI may be provided to a physician to whom you have been referred for evaluation to ensure that the physician has the necessary information to diagnose or treat you. We may also share your PHI from time-to-time to another physician or health care provider (e.g., a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.We may also share your PHI with people outside of our practice that may provide medical care for you such as home health agencies.

We may use and disclose your PHI to obtain payment for services. We may provide your PHI to others in order to bill or collect payment for services. There may be services for which we share information with your health plan to determine if the service will be paid for.

PHI may be shared with the following with billing companies and health plans, collection agencies, and government agencies in order to assist with qualifications of benefits. For example you are seen at our practice for a procedure. We will need to provide a listing of services such as x-rays to your insurance company so that we can get paid for the procedure. We may at times contact your health care plan to receive approval PRIOR to performing certain procedures to ensure the services will be paid for. This will require sharing of your PHI.

We may use or disclose, as-needed, your PHI in order to support the business activities of this practice which are called health care operations.

- Training students, other health care providers, or ancillary staff such as billing personnel to help them learn or improve their skills.
- Quality improvement processes which look at delivery of health care and for improvement in processes which will provide safer, more effective care for you.
- Use of information to assist in resolving problems or complaints within the practice.

We may use and disclosure your PHI in other situations without your permission:

- If required by law: The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. For example, we may be required to report gunshot wounds or suspected abuse or neglect.
- Public health activities: The disclosure will be made for the purpose of controlling disease, injury or disability and only to public health authorities permitted by law to collect or receive information. We may also notify individuals who may have been exposed to a disease or may be at risk of contracting or spreading a disease or condition.

- Health oversight agencies: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- Legal proceedings: To assist in any legal proceeding or in response to a court order, in certain conditions in response to a subpoena, or other lawful process.
- Police or other law enforcement purposes: The release of PHI will meet all applicable legal requirements for release.
- Coroners, funeral directors: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law
- Medical research: We may disclose your protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
- Special government purposes: Information may be shared for national security purposes, or if you are a member of the military, to the military under limited circumstances.
- Correctional institutions: Information may be shared if you are an inmate or under custody of law which is necessary for your health or the health and safety of other individuals.
- Workers' Compensation: Your protected health information may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs.

Other uses and disclosures of your health information.

- Business Associates: Some services are provided through the use of contracted entities called "business associates". We will always release only the minimum amount of PHI necessary so that the business associate can perform the identified services. We require the business associate(s) to appropriately safeguard your information. Examples of business associates include billing companies or transcription services.
- Health Information Exchange: We may make your health information available electronically to other healthcare providers outside of our facility who are involved in your care.
- Fundraising activities: We may contact you in an effort to raise money. You may opt out of receiving such communications.
- Treatment alternatives: We may provide you notice of treatment options or other health related services that may improve your overall health.
- Appointment reminders: We may contact you as a reminder about upcoming appointments or treatment.

We may use or disclose your PHI in the following situations UNLESS you object.

- We may share your information with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. For example, we may discuss post procedure instructions with the person who drove you to the facility unless you tell us specifically not to share the information.
- We may use or disclose protected health information to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your location, general condition or death.
- We may use or disclose your protected health information to an authorized public or private entity to assist in disaster relief efforts.

The following uses and disclosures of PHI require your written authorization:

- Marketing
- Disclosures of for any purposes which require the sale of your information
- Release of psychotherapy notes: Psychotherapy notes are notes by a mental health professional for the purpose of documenting a conversation during a private session. This session could be with an individual or with a group. These notes are kept separate from the rest of the medical record and do not include: medications and how they affect you, start and stop time of counseling sessions, types of treatments provided, results of tests, diagnosis, treatment plan, symptoms, prognosis.

All other uses and disclosures not recorded in this Notice will require a written authorization from you or your personal representative.

Written authorization simply explains how you want your information used and disclosed. Your written authorization may be revoked at any time, in writing. Except to the extent that your doctor or this practice has used or released information based on the direction provided in the authorization, no further use or disclosure will occur.

Your Privacy Rights

You have the right to see and obtain a copy of your protected health information.

This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. If requested we will provide you a copy of your records in an electronic format. There are some exceptions to records which may be copied and the request may be denied. We may charge you a reasonable cost based fee for a copy of the records.

You have the right to request a restriction of your protected health information.

You may request for this practice not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. We are not required to agree with these requests. If we agree to a restriction request we will honor the restriction request unless the information is needed to provide emergency treatment. **There is one exception:** we must accept a restriction request to restrict disclosure of information to a health plan if you pay out of pocket in full for a service or product unless it is otherwise required by law.

You have the right to request for us to communicate in different ways or in different locations.

We will agree to reasonable requests. We may also request alternative address or other method of contact such as mailing information to a post office box. We will not ask for an explanation from you about the request.You may have the right to request an amendment of your health information.

You may request an amendment of your health information.

If you feel that the information is not correct along with an explanation of the reason for the request. In certain cases, we may deny your request for an amendment at which time you will have an opportunity to disagree.

You have the right to a list of people or organizations who have received your health information from us.

This right applies to disclosures for purposes other than treatment, payment or healthcare operations. You have the right to obtain a listing of these disclosures that occurred after April 14, 2003. You may request them for the previous six years or a shorter timeframe. If you request more than one list within a 12 month period you may be charged a reasonable fee.

Additional Privacy Rights

- You have the right to obtain a paper copy of this notice from us, upon request. We will provide you a copy of this Notice the first day we treat you at our facility. In an emergency situation we will give you this Notice as soon as possible.
- You have a right to receive notification of any breach of your protected health information.

Complaints

If you think we have violated your rights or you have a complaint about our privacy practices you can contact: **Contact our office official Jessica Parry.**

You may also complain to the United States Secretary of Health and Human Services if you believe your privacy rights have been violated by us.

If you file a complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on May 22, 2017

Stansell Dentistry Associates

Acknowledgement of Receipt

Of Notice of Privacy Practices

Patient Name & Address:

____

____

____

I have received a copy of the Notice of Privacy Practices for the above named practice.

________________________________ ______________________

Signature Date

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❏ The individual refused to sign
- ❏ An emergency existed & a signature was not possible at the time.
- ❏ A copy was mailed with a request for a signature by return mail.
- ❏ Unable to communicate with patient for the following reason: ____________________________
- ❏ Other: ____

____

____

Prepared By ______________________________________

Signature ______________________________________

Date ______________________________________