

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate. Your email will not be shared and will be used for the sole purpose of communication with us. We may ask for copies of your driver's license and insurance card.

**CONTACT INFORMATION**

NAME \_\_\_\_\_ SS# \_\_\_\_\_ DOB \_\_\_\_\_

ADDRESS \_\_\_\_\_

HOME PHONE # \_\_\_\_\_ CELL # \_\_\_\_\_ WORK # \_\_\_\_\_

BEST WAY TO CONTACT YOU? \_\_\_\_\_ EMAIL \_\_\_\_\_

EMPLOYER \_\_\_\_\_ DENTAL INSURANCE YES NO

EMERGENCY CONTACT \_\_\_\_\_ PHONE \_\_\_\_\_

**IF PATIENT MINOR--** MOTHER \_\_\_\_\_ FATHER \_\_\_\_\_

**MEDICAL INFORMATION**

MEDICAL DOCTOR \_\_\_\_\_ PHONE \_\_\_\_\_

CURRENT MEDICATIONS \_\_\_\_\_

PHARMACY \_\_\_\_\_

ARE YOU UNDER THE CARE OF A DR.? WHY? \_\_\_\_\_ DATE OF LAST EXAM \_\_\_\_\_

**HAVE YOU EVER BEEN TOLD YOU NEED TO TAKE ANTIBIOTICS PRIOR TO ANY DENTAL TREATMENT?** YES NO

HAVE YOU BEEN IN THE HOSPITAL OR BEEN DIAGNOSED WITH A DISEASE SINCE YOUR LAST DENTAL VISIT? IF SO WHAT?

**PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU HAVE HAD OR CURRENTLY HAVE**

- |                         |                          |                  |                        |                  |
|-------------------------|--------------------------|------------------|------------------------|------------------|
| Heart Valve Replacement | Stroke                   | Asthma           | Blood Disorder/Disease | Tuberculosis     |
| Rheumatic Fever         | Low Blood Pressure       | Sinus Trouble    | HIV or AIDS            | Lung Disease     |
| Heart Disease/Attack    | <b>Joint Replacement</b> | GERD             | Cancer or Tumor        | Epilepsy         |
| Heart Murmur            | <b>Diabetes</b>          | Anorexia/Bulimia | Radiation Treatment    | Hepatitis B or C |
| High Blood Pressure     | Drug Addiction           | Mental Disorders | Chemotherapy           | Liver Disease    |

Other \_\_\_\_\_

**PLEASE CIRCLE ANY OF THE FOLLOWING THAT YOU ARE TAKING OR HAVE TAKEN**

- |                          |                |                 |                         |
|--------------------------|----------------|-----------------|-------------------------|
| Cortisone Drugs/Steroids | Blood Thinners | Bisphosphonates | Tranquilizers/Sedatives |
|--------------------------|----------------|-----------------|-------------------------|

**PLEASE CIRCLE IF YOU HAVE BEEN TOLD YOU ARE ALLERGIC TO THE FOLLOWING**

- |                   |                  |             |       |
|-------------------|------------------|-------------|-------|
| PENICILLIN        | CODEINE          | ASPIRIN     | LATEX |
| DENTAL ANESTHETIC | HOUSEHOLD BLEACH | OTHER _____ |       |

**WOMEN ONLY**

Are you pregnant? YES NO If yes, Due Date \_\_\_\_\_ Breastfeeding? YES NO

PLEASE COMPLETE BOTH SIDES

CONFIDENTIAL UPDATE CONTINUED

**INSURANCE PURPOSES ONLY**

I understand and agree that I am responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentists or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges, to the extent permitted under applicable law. I authorize release of any information relating to my dental treatment to my insurance provider.

**PRIMARY INSURANCE**

SPONSOR/EMPLOYEE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ID# \_\_\_\_\_ GROUP # \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

**SECONDARY INSURANCE**

SPONSOR/EMPLOYEE \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_

SS# \_\_\_\_\_ DOB \_\_\_\_\_ EMPLOYER \_\_\_\_\_

ID# \_\_\_\_\_ GROUP# \_\_\_\_\_ INSURANCE COMPANY \_\_\_\_\_

Signature **x** \_\_\_\_\_ Date \_\_\_\_\_

I hereby authorize payment for dental services rendered to Stonebridge Dental Associates/Gerald L. Coates, Jr., DMD.

Signature **x** \_\_\_\_\_ Date \_\_\_\_\_

**PRIVACY POLICY**

Contact Officer Linda White Email linda@stonebridgesmiles.com

Telephone (252) 447-3100 Fax (252) 447-0144

Address 92 Stonebridge Trail, Havelock, NC 28532

**If you would like a copy of our privacy policy and how we utilize your information we will be happy to supply you a copy of our HIPAA policy. Your information is not shared with anyone without your expressed consent and authorization.**

**PATIENT HIPAA ACKNOWLEDGEMENT**

I, \_\_\_\_\_, acknowledge that I understand Stonebridge Dental Associates privacy policy and received if I requested so.

Signature **x** \_\_\_\_\_ Date \_\_\_\_\_

If you do not agree to sign this form, our office must indicate why you declined to do so.

Reason for refusal \_\_\_\_\_

If refused, as HIPAA officer I have reviewed the patients concerns.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**RELEASE OF INFORMATION**

I, \_\_\_\_\_, hereby authorize release of information to the following:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Information authorized Dental/ Medical Information  Financial