Eric M. Staeben DDS **39 Baribeau Dr.** **207-729-4144**

Brunswick, Maine 04011

Name_____DOB_____

Address_____Phone#_____

City/State/Zip_____

SSN_____ Gender Identity: _____

E-mail address _____

What is the reason for your visit: _____

How did you hear about us: _____

Dental Insurance: YES / NO

Who is the subscriber of the insurance? _____DOB_____

Subscriber's Employer_____

Insurance Co. Name_____

Claims Address_____

Insurance Phone_____

Subscriber ID_____ Group #_____

By checking this circle ○

- I authorize my insurance to pay my benefits directly to the dentist for all services 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 History

When were you last seen by a dentist? _____

Was this for preventive care or problem specific? _____

Name of previous dentist_____

Have you experienced any unfavorable reaction from previous dental care? If so please explain:

_____

_____

Please circle if you are having dental problems with any of the following:

Cavities Toothache Teeth Sensitive

Trauma Gum Infections Color of teeth

Orthodontics Jaw Sounds other_____

YES NO Do you use a fluoride toothpaste?

YES NO Do you use any other form of fluoride? Type_____

Health History

Are you in good health? YES NO

Primary Care Physician_____

Date of last physical? _____

Have you ever been hospitalized? YES NO

Please give reasons and dates_____

_____

Are you allergic to anything? YES NO If yes, what? _____

Are you currently taking any medications? YES NO If yes, what?

_____

_____

_____

_____

Are you or have you ever taken bisphosphonates (osteoporosis medication)? _____

Are you or have you ever taken a blood thinner? _____

Please circle if you have been treated for any of the following:

Heart disease/murmur	Heart Attack/Stroke	Bleeding/transfusions	Asthma
Liver/GI disease	Anemia	Diabetes	Mental Delays
Kidney disease	Rheumatic Fever	Hepatitis	Physical Delays
Speech/hearing	Seizure	Osteoporosis	HIV/AIDS
Personality/Social	Heart Shunt	Blood Dyscrasias	
Cancer/Tumors	Recurrent headaches	Frequent Infections	
Joint replacement/	Thyroid Irregularities	Congenital Birth Defects	

Other: _____

Artificial Joint: YES NO

If circled yes to artificial joint, heart attack or shunt, does your physician require you to take antibiotic medication prior to dental appointments? _____

Emergency Contact Information:

Name _____

Relationship to you: _____Phone:_____

I acknowledge that the above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Signature_____Date_____

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

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use my protected health information to carry out:

- Treatment (including direct or indirect treatment by other health care providers involved in my treatment).
- Obtaining payment from a third party payers (e.g. my insurance company)
- The day to day healthcare operations of the practice.

I have also been given the right to review and secure a copy of your "Notice of Privacy Practices", which contains a more complete description of the uses of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my health information is used and shared to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoked this consent is not affected.

Print Patient Name: _____Relationship to Patient: _____

Signature: _____ Date: _____

BROKEN APPOINTMENT POLICY

For you, a missed dental appointment causes a delay in treatment that was recommended to help improve your dental health.

For our office, a missed appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality care that every patient deserves.

We understand that things happen and schedules do change and ask that you give us the courtesy of 48 hour notice for any appointment changes to avoid a $50.00 cancellation fee.

Patient /Guardian Signature _____Date_____