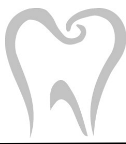


Julie L. Stante, DDS

COSMETIC & FAMILY DENTISTRY

Age: ____________ Today's Date: ___________

Patient Name: ____ Date of Birth____________ Sex: ______

Last First Initial

If Child, Parent's Name: ____________________________________

How do you wish to be addressed? ______________________

Single Married Separated Divorced Widowed Minor

Residential Address: __________________________________
Street

City: ______________________ State: _______ Zip: ________

Phone: Res _________________ Bus ____________________

Cell _______________________ Fax ____________________

Email ____

Patient/Parent Social Security No. ____________________

Spouse/Parent Social Security No. ____________________

Patient/Parent Employed By _____________________________

Present Position ____________________________________

How Long Held _____________________________________

Spouse/Parent Name _________________________________

Spouse Employed By _________________________________

Present Position ____________________________________

How Long Held _____________________________________

Who is responsible for this account ____________________

Drivers License No. __________________________________

Method of Payment: Insurance ___ Cash ___ Credit Card ___

Other Family Members in the Practice __________________

____

Whom may we thank for this referral ___________________

Someone to notify in case of emergency:

Name: _______________________ No. __________________

Primary Dental Insurance

Insured Name _____________________ DOB _________

Relationship to patient ______________________________

Insured Social Security No. ___________________________

Employer Name ____________________________________

Insurance Company _________________________________

Phone No. ____

Secondary Dental Insurance

Insured Name _____________________ DOB _________

Relationship to patient ______________________________

Insured Social Security No. ___________________________

Employer Name ____________________________________

Insurance Company _________________________________

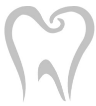
Phone No. ____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.
I consent to the dentist use and disclosure of my (or my child's) records to carry out treatment, to obtain payment and for those activities and health care operations that are related to treatment or payment. My consent to disclosure of records shall be effective until I revoke it in writing.
I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental insurance may pay less that the actual bill for services and that I am financially responsible for payment in full for all accounts.
I attest to the accuracy of the information on this page.

Patient/Guardian Signature _________________________
Today's Date ______________________________________

REGISTRATION



Julie L. Stante, DDS
COSMETIC & FAMILY DENTISTRY

Patient's Name ____

Last First Date of Birth

1. Purpose if initial visit ______________________
2. Are you aware of a problem? ______________________
3. How long since your last visit? ______________________
4. What was done at that time? ______________________
5. Name of previous dentist? ______________ Tel. ________
6. When was the last time your teeth were cleaned? ______________

CIRCLE THE APPROPRIATE ANSWER. IF YOU DON'T KNOW THE ANSWER, PLEASE WRITE "I DON'T KNOW" ON THE LINE AFTER THE QUESTION.

7. Have you made regular visits? .... YES NO
   How often? ____________
8. Were dental radiographs taken? .... YES NO
9. Have you lost any teeth or have any teeth been removed? .... YES NO
   Why? ____________
10. Have they been replaced? .... YES NO
11. How have they been replaced?
   A. Fixed Bridge Age ______ B. Removable Bridge Age ______
   C. Denture Age ______ D. Implant Age ______
12. Are you happy with the replacement? .... YES NO
   If NO, explain? ______________________
13. Have you ever had problems or complications with dental treatment? ...... YES NO
   If YES, explain ______________________
14. Do you clench or grind your teeth? .... YES NO
15. Does your jaw click or pop? .... YES NO
16. Have you ever experienced any pain or soreness in the muscles in your face or around your ear .... YES NO
17. Do you have frequent headaches, neck aches or shoulder aches? .... YES NO
18. Does food get caught in your teeth? .... YES NO
19. Are any of your teeth sensitive to: Hot? Cold? Sweets? Pressure?
20. Do you gums bleed or hurt? .... YES NO
21. Do you experience dry mouth? .... YES NO
22. How often do you brush your teeth? ____________ When? ____________
23. Do you use dental floss? .... YES NO
   How often? ____________
24. Are any of your teeth loose, tipped, shifted or chipped? .... YES NO
25. Are you happy with the appearance of your teeth? .... YES NO
   If NO, explain ______________________
26. How do you feel about your teeth in general? ______________________
27. Do you ever feel your breath is offensive? .... YES NO
28. Have you ever had gum treatment or surgery? .... YES NO
   If YES, when and where in your mouth? ______________________
29. Have you ever had orthodontics? .... YES NO
30. If treatment is necessary, what is your main concern? Fear Finances Time None
31. Would you like Nitrous Oxide (laughing gas) for dental procedures? YES NO
32. Have you ever had an unpleasant dental experience? .... YES NO
   If YES, explain ______________________

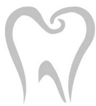
I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

Patient's/ Guardian's signature: ______________________ Date: ____________

Dentist's signature: ______________________ Date: ____________

COMMENTS

DENTAL HISTORY



Julie L. Stante, DDS
COSMETIC & FAMILY DENTISTRY

Patient's Name ____

Last First Date of Birth

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

Name of primary care provider or medical specialist. ______________________________

Have you ever been hospitalized or had major operation? Yes No If yes: ______________________

Have you ever had a serious head/neck injury? Yes No If yes: ______________________

Are you taking any prescription or over the counter medications, pills or drugs? Yes No If yes: ______________________

____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No If yes: ______________________

Have you ever used tobacco products? Yes No If yes: ______________________

Women: Are you…… Pregnant/Trying to get pregnant? Nursing? Taking Oral Contraceptives?

Are you allergic to the following? Keflex Penicillin Sulfa Codeine Acrylic Metal Latex Local Anesthetics

Other? ____

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

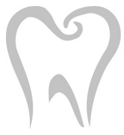
Acid Reflux	Yes	No	Drug Addiction	Yes	No	Irregular Heartbeat	Yes	No
AIDS/HIV Positive	Yes	No	Easily Winded	Yes	No	Kidney Disease	Yes	No
Alzheimer's Disease	Yes	No	Emphysema	Yes	No	Liver Disease	Yes	No
Anaphylaxis	Yes	No	Epilepsy or Seizures	Yes	No	Low Blood Pressure	Yes	No
Anemia	Yes	No	Excessive Bleeding	Yes	No	Lung Disease	Yes	No
Anxiety	Yes	No	Excessive Thirst	Yes	No	Mitral Valve Prolapse	Yes	No
Arthritis/Gout	Yes	No	Fainting Spells/Dizziness	Yes	No	Osteoporosis	Yes	No
Artificial Heart Valve	Yes	No	Frequent Cough	Yes	No	Pain in Jaw Joints	Yes	No
Artificial Joint	Yes	No	Frequent Headaches	Yes	No	Psychiatric Care	Yes	No
Asthma	Yes	No	Glaucoma	Yes	No	Radiation Treatments	Yes	No
Blood Disease/Cancer	Yes	No	Heart Attack/Failure	Yes	No	Renal Dialysis	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Rheumatoid Arthritis	Yes	No
Bruise Easily	Yes	No	Heart Pacemaker	Yes	No	Seasonal Allergies	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No	Shingles	Yes	No
Chemotherapy	Yes	No	Hepatitis A, B or C	Yes	No	Sinus Trouble	Yes	No
Cold Sores/Fever Blisters	Yes	No	High Blood Pressure	Yes	No	Stomach/Intestinal Disease	Yes	No
Congenital Heart Disorder	Yes	No	High Cholesterol	Yes	No	Stroke	Yes	No
Cortisone Medicine	Yes	No	Hives or Rash	Yes	No	Swelling of Limbs	Yes	No
Diabetes	Yes	No	HPV	Yes	No	Thyroid Disease	Yes	No
Difficulty Swallowing	Yes	No	Hypoglycemia	Yes	No	Tonsilitis/Tonsilectomy	Yes	No

Have you ever had any serious illness not listed above? Yes No If yes: ______________________

Comments:

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

Signature of Patient, Parent or Guardian: ______________________________ Date: ______________



Julie L. Stante, DDS
COSMETIC & FAMILY DENTISTRY

Welcome! Thank you for selecting us as your dental health care provider. Our goal is to provide you and your family with optimal dental care. We want you to feel welcome and as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved in treatment decisions. This includes understanding your treatment plan as well as our financial policy.

Financial Policy

Payment for care is expected the day services are rendered. If you have dental insurance to supplement the cost of your dental treatment, we will assist you in receiving your maximum allowable benefits. Dental insurance benefits are designed to pay only a portion of the cost of your treatment. Your dental benefits' carrier may pay less than the actual bill or estimate of services. Our team will do their best to accurately estimate your payment portion, but this is **ONLY AN ESTIMATION**. Estimated co-payment and deductible will be collected on the day of service.

Our team will work with you to design an affordable payment plan for fees not covered by insurance. Personal checks and major credit cards are welcome. We also offer extended no interest payment plans. Please note, any balances not received within 90 days of statement date will be charged a **20%** interest fee.

Our payment options are as follows:

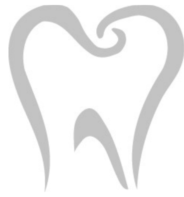
- Cash or Personal Check
  - A 5% accounting courtesy deduction is available on all services over $500 when the service fee is paid in full on the day of treatment. There is a $30 fee for all returned checks.
- VISA, MasterCard, Discover or American Express
- Care Credit
  - This payment plan allows our patients to finance their dental services over $300 with interest free for up to 12 months. They also offer long term plans with a low rate. Pre-approval is required for Care Credit financing

I understand and agree that I am responsible for the balance on my account for any professional dental services rendered, and shall be responsible for all cost incurred including but not limited to reasonable attorney fees in the event collection actions must be taken." Responsible party signature required if patient is a minor or still covered under parent's insurance plan.

Please allow us the courtesy of 48hrs if you need to cancel or reschedule an appointment. Failure to do so will incur a missed appointment fee of $75. ____initial

Patient Signature:____ Date:__________

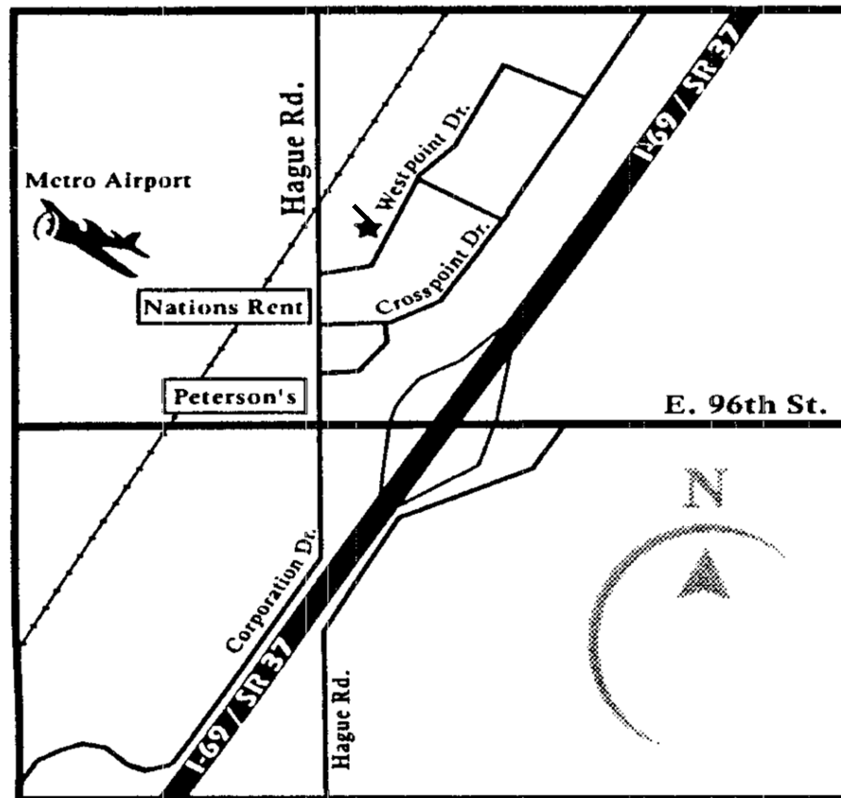
Responsible Party (Insured) of Dependent Signature:________________________ Date: _________



Julie L. Stante, DDS

COSMETIC & FAMILY DENTISTRY

9810 Westpoint Dr. Suite 100 Indianapolis, IN 46256
317-579-1875 Fax 317-579-1879



Directions from the North:
-Take I-69 S, exit at 96th St.
-Turn R on 96th St. Stay in R lane.
-Turn R (North) onto Hague Rd.
-Turn R on Westpoint Dr. (last road before the railroad tracks)
-9810 is the first building on your L.

Directions from the South:
-Take I-69 N, exit at 96th St.
-Turn L on 96th St. Move to the far R lane.
-Turn R (North) onto Hague Rd.
-Turn R on Westpoint Dr. (last road before the railroad tracks)
-9810 is the first building on your L.