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

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/vaping 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/Dialysis	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	Rheumatoid Arthritis	Yes	No
Blood Transfusion	Yes	No	Heart Murmur	Yes	No	Seasonal Allergies	Yes	No
Bruise Easily	Yes	No	Heart Pacemaker	Yes	No	Shingles	Yes	No
Cancer	Yes	No	Hemophilia	Yes	No	Sinus Trouble	Yes	No
Chemotherapy	Yes	No	Hepatitis A, B or C	Yes	No	Sleep Apnea	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

Patient's Name _____
Last First Date of Birth

1. Purpose of 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
8. Were dental radiographs taken? ..... YES NO
9. Have your wisdom teeth been removed? ..... YES NO
10. Have Any other teeth removed? _____ YES NO
    If Yes, 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 your gums bleed or hurt when you brush? ..... 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. Are you interested in whitening your teeth? ..... YES NO
27. How do you feel about your teeth in general? _____
28. Do you ever feel your breath is offensive? ..... YES NO
29. Have you ever had gum disease, gum graft or surgery? ..... YES NO
    If YES, when and where in your mouth? _____
30. Have you ever had orthodontics? ..... YES NO
31. If treatment is necessary, what is your main concern? Fear Finances Time None
32. Would you like Nitrous Oxide (laughing gas) for dental procedures? YES NO
33. 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

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 **10%** interest fee.

Our payment options are as follows:

- VISA, MasterCard, Discover or American Express
- Care Credit
  This payment plan allows our patients to finance their dental services over $1000 with interest free for up to 6 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. There will be a $30 returned check fee.

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

NOTICE OF PRIVACY PRACTICES

I have been offered the office's Notice of Privacy Practices.

Signature: _____ Date: _____

Parent, Legal Guardian, Power of Attorney, Court Appointed Legal Guardian

I, _____, as the personal representative of, _____, have received a copy of this office's Notice of Privacy Practices.

Signature: _____ Date: _____

AUTHORIZATION FOR FAMILY COMMUNICATION

I authorize the dental office of Julie Stante, DDS to release the following information about my health care (please check all that apply).

☐ Any and all information, including but not limited to:
Information necessary to schedule, confirm, cancel or reschedule appointments.
Information about test results.
Information about prescriptions.
Information about dental treatment presented.
Information about my bills or account.
I grant permission to this individual to bring my child to their appointment.

☐ I choose NOT to authorize anyone at this time.

This information applies to the following individual(s):

Name:	Relationship to patient:
_____	_____
_____	_____
_____	_____

I understand that this authorization is valid until revoked by the patient, or the patient's parent/guardian.

Signature: _____ Date: _____

Dr. Julie Stante
9810 Westpoint Dr. #100
Indianapolis, IN 46256

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while it is in effect. This notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such applicable law permits the changes. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and health care operations. For example:
Treatment: We may use your health information for treatment or disclose it to a dentist, physician or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. We may also disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your information to help these organizations conduct quality assessment and improvement activities, review the competence or qualifications of health care professionals, or detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- as required by law;
- for public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- to report adult abuse, neglect, or domestic violence;

- in response to court and administrative orders and other lawful processes;
- to law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- to coroners, medical examiners, and funeral directors;
- to an organ procurement organizations;
- to avert a serious threat to health or safety;
- in connection with certain research activities;
- to the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- to correctional institutions regarding inmates; and
- as authorized by state worker's compensation laws.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs, and postage. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we may—but are not required to—prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this notice for more information about fees.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information over the last 6 years (but not before April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for more information about fees.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. You must specify in your request the alternative means or location, and provide satisfactory explanation how you will handle payment under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.

If you believe that:

- we may have violated your privacy rights,
- we made a decision about access to your health information incorrectly,
- our response to a request you made to amend or restrict the use or disclosure of your health information was incorrect, or
- we should communicate with you by alternative means or at alternative locations,

you may contact us using the information listed below. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Provider Contact Office: _____

Telephone: _____ Fax: _____

E-Mail: _____

Address: _____