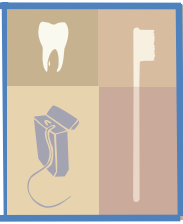


Neil S. Stearns, DMD
 216 Engle Street—Suite 204
 Englewood, New Jersey 07631



Please complete all sections

Name: _____ Male Female
Last First MI Title

Address: _____ City: _____ State: _____ Zip: _____

SSN: _____ DOB: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Employer: _____

Occupation: _____ Marital Status: M S D W DP

PRIMARY DENTAL INSURANCE	SECONDARY DENTAL INSURANCE
Subscriber Name: _____	Subscriber Name: _____
Subscriber SSN/ID: _____	Subscriber SSN/ID: _____
Insurance Company Name: _____	Insurance Company Name: _____
Relationship to patient: _____	Relationship to patient: _____
Subscriber Employer: _____	Subscriber Employer: _____
Subscriber DOB: _____	Subscriber DOB: _____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Neil S. Stearns, DMD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist for proper dental care.

Patient/Guardian _____

MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____ Your current physical health is: Good Fair Poor

Are you currently under the care of a physician: Yes No

Please explain if yes: _____

Do you use tobacco in any form? Yes No

Have you had any metal rods, pins or implants placed? Yes No

Are you taking any medications? Yes No

Please list each one: _____

Y	N	Conditions	Y	N	Conditions	Y	N	Conditions	Y	N	Allergies
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Facial Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Angina Pectoris	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Problems	<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Blood Transfusion	<input type="checkbox"/>	<input type="checkbox"/>	HIV+ AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Seizures			
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	STDs			
<input type="checkbox"/>	<input type="checkbox"/>	Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Shingles			
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B, or C	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Disease			
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High/Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers			

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

How may we help you today? _____

Your current dental health is: Good Fair Poor

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had gum treatment? Yes No

Do you now or have you had any pain/discomfort in your jaw joint? (TMJ)? Yes No

Are you under stress? Yes No

Do you like your smile? Yes No

Is there anything you would like to change about your smile? Yes No

Are you happy with the color of your teeth? Yes No

Do your gums bleed? Yes No

How many time do you: Floss/Week _____ Brush/day _____

Are your teeth sensitive to heat, cold or anything else? _____

Have you lost any teeth? Yes No

Have you ever had a serious/difficult problem with any previous dental work? Yes No

Have you ever had any unfavorable dental experiences? Yes No

When was your last dental cleaning? _____

When was your last dental visit? _____

How can we accommodate you better during your dental visit? _____

Here at our office, Dr. Stearns offers a wide variety of services to enhance and keep your smile beautiful. Please circle any services below you would like our friendly staff to discuss with you during your visit.

Please circle

Zoom Whitening

Veneers/Laminates Invisalign

Facial Dermal Fillers or Botox

PAYMENT AND INSURANCE

We are committed to providing you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, our policy, or your financial responsibility. By signing below you agree to be financially responsible for any and all medical and or dental services provided. If you have dental insurance, please provide is with a current copy of the card. You are responsible for payment of any co-pay, deductible, or co-insurance amount or non-covered services.

Payment is expected at the time of the visit/service. We accept cash, checks and credit cards.

Initial here _____

We also require credit card information and authorization. Charges or refunds to your card will only be made once your insurer has provided us with your EOB. (explanation of benefits). THIS MEANS, once we receive payment, we will bill you for the balance due. After the first billing cycle, any remaining balance will be charged to your card on file. Failure to provide current insurance or credit card information will result in service charges to your account.

<input type="checkbox"/> Visa	_____
<input type="checkbox"/> MasterCard	Signature _____
<input type="checkbox"/> American Express	Credit Card # _____ Exp. date _____

**** 48 hours notice is required for schedule changes. All appointments rescheduled or “no show” after this time will be charged for Dr. Stearns or the Hygienist time. The charge will be \$105 per scheduled hour. A courtesy call will be given 2 days prior to appointments, however, please do not rely solely on this call. At times, phone lines are busy, machines are not left on or tape is full, or patients are hard to get a hold of. It is the patient’s responsibility to know when they have scheduled THEIR time with us. Helping us keep your appointments and being on time will in turn help you.**

The undersigned patient hereby authorizes this practice to submit Insurance Carrier Claim Forms on behalf of the patient without further signature authorization. This form also authorizes the practice and/or patient to receive **directly from the Insurance Carrier. All claim forms will be submitted to the notation “Signature on File”.** I understand that although I have given insurance information, insurance is not a guarantee of benefits and I am responsible for my bill and any unpaid insurance claims. I certify that the information given above is true and correct to the best of my knowledge.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf. I also authorize any pre and post op photos of my dental treatment to be used for any marketing and/or educational purposes. If my photos are chosen my identity will be concealed with my eyes being masked out of photos.

The undersigned patient hereby agrees to the payment and cancellation policy stated above as well as the consent of use of treatment pre and post op photos.

Signature _____ Date _____

Guardian signature (if minor) _____ Date _____