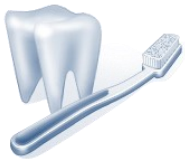
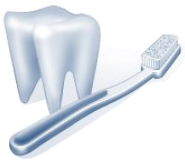


Neil S. Stearns, DMD

216 Engle Street—Suite 204
Englewood, New Jersey 07631



Please provide office with any dental and medical cards, and drivers license.

Completion of all pages is required.

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 as "signature on file"

Responsible Party Signature: _____

Relationship: _____ **Date:** _____

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

PATIENT/GUARDIAN SIGNATURE: _____

How were you referred to our office?

_____

Neil S. Stearns, DMD

Medical Health History

PATIENT NAME: _____

Do you have a personal physician? Yes No **Pharmacy Number:** _____

Physician's Name: _____ Physician's Phone: _____

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 joint replacements; metal rods, pins or non dental implants placed? Yes No

Location of replacement? _____ **Pre-med Required? Yes / No**

Are you taking any medications? Yes No

Please list each one: _____

Y	N	Conditions
☐	☐	Acid Reflux
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion: _____
☐	☐	Cancer: Year_____
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Diabetes: Type I or II
☐	☐	Difficulty Breathing
☐	☐	Thyroid: Hyper/Hypo

Y	N	Conditions
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Fever Blisters
☐	☐	Freq. Headaches/Migraines
☐	☐	Glaucoma/Cataracts
☐	☐	HIV/AIDS
☐	☐	Heart Murmur/Disease
☐	☐	Heart Attack: Yr._____
☐	☐	Hemophilia
☐	☐	Hepatitis A, B, or C
☐	☐	High or Low BP
☐	☐	Joint Replacement
☐	☐	Tuberculosis

Y	N	Conditions
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	High/Low Cholesterol
☐	☐	Mitral Valve Prolapse
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation or Chemo
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	STDs
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Sleep Apnea/Snoring
☐	☐	Stroke
☐	☐	Ulcers

Y	N	Allergies
☐	☐	Anesthetics
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Erythromycin
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Any other conditions or allergies: _____

_____

_____

_____

_____

_____

_____

_____

WOMEN ONLY: Are you Pregnant ? ☐ Yes ☐ No Number of weeks? _____

Are you currently taking Birth Control? Or hormonal replacement? _____ Currently Nursing? _____

I understand that the information that I have given today is correct and accurate 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. I will not hold my dentist or any other member of his staff responsible for any action they take or do not take because of errors or omission that I may have made in the completion of this form.

Signature: _____ Date: _____

Neil S. Stearns, DMD

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 (periodontal) 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 times 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? _____

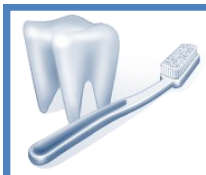
When was your last dental visit? _____

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.

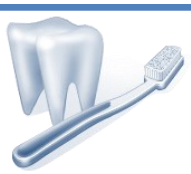
Please circle

Teeth Whitening Veneers/Laminates Invisalign (clear braces)



PAYMENT, INSURANCE, & CANCELLATION POLICY

Neil S. Stearns, DMD



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. 18% Finance charges apply to outstanding balance; unpaid balances are subject to $15 late fee, and $10 thereafter. Extended payment plans must be made prior to treatment. Payment is expected at the time of the visit/service. We accept cash, checks and credit cards. (Amex, Visa, MasterCard, Discover, Care Credit)

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.

☐ Visa
☐ MasterCard
☐ American Express
☐ Discover
☐ HSA/FSA

_____
Signature

_____ _____
Credit Card # Exp. date

Billing zip code _____ CVV#:_____

**** 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, email or text message reminder will be given 2 days prior to appointments, however, please do not rely solely on this call. At times, voice mail is not set up, patients opt out of text/email reminder, or do not return calls. 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 herby 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 herby agrees to the payment and cancellation policy stated above as well as the consent of use of treatment pre and post op photos (smile only, eyes/face blocked out)

Signature _____Date_____

Guardian signature (if minor)_____ Date_____