STONE VALLEY DENTAL
Dr. Yvonne Chu-Hyland

Welcome! *Our specialty is creating smiles and to do this we treat people, not just teeth. We care about your total health and appreciate your time in completing this health history.*

Patient Information

Date _____
Patient _____
Last First Middle
Mailing Address _____
_____
Street City State Zip
Sex: [ ] M [ ] F Age _____ Birthdate _____

Email Address _____
(office visits are confirmed via email)
Patient SS# _____

Occupation _____

Employer _____

Employer Phone_____

[ ] Single [ ] Married [ ] Widowed [ ] Separated [ ] Divorced

Spouse's Name _____

Spouse's Employer _____

Whom may we thank for referring you? _____

Dental Insurance Information

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? Yes ____ No _____
If yes, Insurance Co. _____
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ 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 payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____

Does patient have a Health Savings Account? _____

PHONE NUMBERS

Home _____ Work _____ Ext _____ Cell _____ Spouse's Work _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____ Relationship _____

Home Phone _____ Work Phone _____ Cell Phone _____

DENTAL HISTORY

Reason for today's visit _____
_____

Date of last dental visit _____
Date of last dental x-rays _____
Name of previous dentist _____

Place a mark on "Yes" or "No" to indicate if you have Or had any of the following:

Bad Taste	[ ] Yes [ ] No	Bad Breath	[ ] Yes [ ] No	Lip or Cheek Biting	[ ] Yes [ ] No
		Bleeding Gums	[ ] Yes [ ] No	Loose teeth or broken fillings	[ ] Yes [ ] No
		Blisters on lips or mouth	[ ] Yes [ ] No	Mouth Breathing	[ ] Yes [ ] No
		Burning sensation on tongue	[ ] Yes [ ] No	Mouth pain, brushing	[ ] Yes [ ] No
		Chew on one side of mouth	[ ] Yes [ ] No	Orthodontic treatment	[ ] Yes [ ] No
		Cigarette, pipe, or cigar smoking	[ ] Yes [ ] No	Periodontal treatment	[ ] Yes [ ] No
		Clicking or popping jaw	[ ] Yes [ ] No	Sensitivity to cold	[ ] Yes [ ] No
		Dry mouth	[ ] Yes [ ] No	Sensitivity to heat	[ ] Yes [ ] No
		Dark teeth	[ ] Yes [ ] No	Sensitivity to sweets	[ ] Yes [ ] No
		Fingernail biting	[ ] Yes [ ] No	Sensitivity when biting	[ ] Yes [ ] No
		Food collection between teeth	[ ] Yes [ ] No	Sores or growths in your mouth	[ ] Yes [ ] No
		Grinding teeth	[ ] Yes [ ] No	Unsightly teeth	[ ] Yes [ ] No
		Gums swollen or tender	[ ] Yes [ ] No	How often do you floss? _____	
		Jaw pain or tiredness	[ ] Yes [ ] No	How often do you brush? _____	

Medical History

Physician's Name: _____ Date of last visit: _____
Physician's Address: _____ Physician's Phone Number _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	[ ] Yes [ ] No	Fainting/dizziness	[ ] Yes [ ] No	Prosthetic Replacement	[ ] Yes [ ] No
Anemia	[ ] Yes [ ] No	Glaucoma	[ ] Yes [ ] No	Psychiatric Care	[ ] Yes [ ] No
Arthritis, Rheumatism	[ ] Yes [ ] No	Headaches	[ ] Yes [ ] No	Radiation Treatment	[ ] Yes [ ] No
Artificial Heart Valves	[ ] Yes [ ] No	Heart Murmur	[ ] Yes [ ] No	Respiratory Disease	[ ] Yes [ ] No
Artificial Joints	[ ] Yes [ ] No	Heart Problems	[ ] Yes [ ] No	Rheumatic Fever	[ ] Yes [ ] No
Asthma	[ ] Yes [ ] No	Hepatitis	[ ] Yes [ ] No	Scarlet Fever	[ ] Yes [ ] No
Back Problems	[ ] Yes [ ] No	Type _____		Shortness of Breath	[ ] Yes [ ] No
Bleeding abnormally, with		Herpes	[ ] Yes [ ] No	Sinus Trouble	[ ] Yes [ ] No
Extractions or surgery	[ ] Yes [ ] No	High Blood Pressure	[ ] Yes [ ] No	Skin Rash	[ ] Yes [ ] No
Blood Disease	[ ] Yes [ ] No	HIV Positive	[ ] Yes [ ] No	Stroke	[ ] Yes [ ] No
Cancer	[ ] Yes [ ] No	Jaundice	[ ] Yes [ ] No	Swelling of Feet or Ankles	[ ] Yes [ ] No
Chemical Dependency	[ ] Yes [ ] No	Jaw Pain	[ ] Yes [ ] No	Swollen Neck Glands	[ ] Yes [ ] No
Chemotherapy	[ ] Yes [ ] No	Kidney Disease	[ ] Yes [ ] No	Thyroid Problems	[ ] Yes [ ] No
Circulatory Problems	[ ] Yes [ ] No	Liver Disease	[ ] Yes [ ] No	Tuberculosis	[ ] Yes [ ] No
Congenital Heart Lesions	[ ] Yes [ ] No	Low Blood Pressure	[ ] Yes [ ] No	Tumor or growth on head	
Cortisone Treatments	[ ] Yes [ ] No	Mitral Valve Prolapse	[ ] Yes [ ] No	or neck	[ ] Yes [ ] No
Cough, persistent or bloody	[ ] Yes [ ] No	Nervous Problems	[ ] Yes [ ] No	Ulcer	[ ] Yes [ ] No
Diabetes	[ ] Yes [ ] No	Pacemaker	[ ] Yes [ ] No	Venereal Disease	[ ] Yes [ ] No
Drug use (illegal)	[ ] Yes [ ] No	**For Women Only**:		Weight Loss, unexplained	[ ] Yes [ ] No
Emphysema	[ ] Yes [ ] No	Are you pregnant?	[ ] Yes [ ] No		
Epilepsy	[ ] Yes [ ] No	Due Date _____			
		Are you nursing?	[ ] Yes [ ] No		
		Are you taking BCP?	[ ] Yes [ ] No		

MEDICATIONS

List medications you are currently taking: _____
_____
_____
_____
Pharmacy Name _____
Phone _____

ALLERGIES

[ ] Aspirin
[ ] Barbiturates(sleeping Pills)
[ ] Codeine
[ ] Iodine
[ ] Local Anesthetic
[ ] Penicillin
[ ] Sulfa
[ ] Latex
Other Drugs _____
[ ] **No Known Allergies**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

I consent to treatment as necessary or desirable to the care of the patient first named above, including but not limited to whatever drugs, medicine, performance of operations, and conduct of laboratory, x-ray, or other studies that may be used by the attending doctor or qualified designate. I also acknowledge full responsibility for the payment of such services and agree to pay them in full at the time of service. I acknowledge that it is my responsibility and not an insurance company to pay for any or all services. Any outstanding balance after 30 days may incur a finance charge of 18% per annum or 1-1/2% per month.

Signed _____ Date _____
Patient, Parent Or Agent (must be 18 years or older)

FOR OFFICE USE: Reviewed by Dr. _____ Date _____

Notice Of Privacy Practices

(We have a copy of our Privacy Practice Policies available upon request)

For the use and disclosure of Personal Health Information. Before signing, please read our Privacy Practice Policies to gain a clear understanding of how we may use and disclose your Protected Health Information (PHI). I, _____, have read Stone Valley Dental Privacy Practice Policies and consent to the use and disclosure of my PHI for the purposes of healthcare operations, treatment and payment activities.

I have been offered a copy of Stone Valley Dental Privacy Practice Policies. Signature _____ Date _____

STONE VALLEY DENTAL

FINANCIAL AGREEMENT

This agreement is to inform you of your financial obligation to our practice. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

Stone Valley Dental requires payment in full at time of service. We accept Visa, MasterCard, Discover, American Express, money orders and cash. Checks are accepted only for existing patients with established payment history (a fee of $25 will be charged for return check due to insufficient funds).

Financing options are available by requesting an application from the patient services staff.

Patients with dental insurance: Stone Valley Dental will submit your insurance claims for you **as a courtesy**. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is **ONLY AN ESTIMATE**. We require full payment of your estimated portion. If your insurance company changes then YOU must notify us immediately. **You are responsible for services not covered balances that have not been paid by your insurance, and finance charges for late insurance payments over 60 days. You are responsible for your account regardless of your insurance eligibility and coverage.**

Please bring your current insurance card to your appointments. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. *Note – Any insurance plan that pays the patient directly requires payment in full at the time of service, unless prior financial arrangements have been made.

Broken Appointment: A specific amount of time has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, please be advised that we require a 48-hour notice. If you do not come to your reserved time, a charge of $50 per ½ hour of time will be charged (emergencies are an exception).

Truth & Lending: Late charges or finance charges will be assessed if payment is not received by the 20th of each month. The amount of the late charge is a minimum of $5.00 with a maximum of $20.00. Finance charges are at a rate of 1.25% monthly.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. By signing, you acknowledge the Financial Policy and authorize insurance payments to our office.

Print Name of Responsible Party	Signature of Responsible Party	Date