



Dr. Bob Stinauer
312 W. Main St.
Havana, IL 62644
(309) 543-2975

Dr. John Stinauer
148 N. 5th Ave.
Canton, IL 61520
(309) 226-4717

Dr. Jesse Stinauer
2000 N. Main St.
Lewistown IL 61542
(309) 547-2200

Personal Information

Today's Date: _____
Patient's name: _____
Preferred Name: _____
 male female age: _____
Status: minor single married
Date of birth _____
Social Security # _____
Driver's License # _____
Home Address: _____
Billing Address: _____
(if different) _____
Email Address: _____
Please check preferred number to contact:
 Home # _____
 Work # _____
 Cell # _____
Preferred method of appointment confirmation:
 Text Phone call
Employer: _____
Occupation: _____
Spouse's name: _____
Do you have children? Yes No
How many? _____
Do you have dental insurance?
 Yes No
Do we have a copy of your insurance card? Yes No
Person ultimately responsibly for account: _____
Name: _____
Relation: _____
Referred to us by: _____

Insurance Information

Primary insured's name: _____
Relationship to patient: _____
Primary employer: _____
Primary's date of birth: _____
Primary's social security #: _____
Primary's address: _____
Do you have secondary dental insurance? Yes No
Secondary insured's name: _____
Relationship to patient: _____
Secondary's employer: _____
Secondary's date of birth: _____
Secondary social security #: _____
Secondary's address: _____
Do you have any other supplemental insurance? Yes No
In event of emergency
Emergency contact name: _____
Relationship to patient: _____
Preferred number to contact: _____
Who is your medical doctor: _____
Medical doctor's phone #: _____

Dental Information

Do you require antibiotic premedication before dental treatment? Yes No
If yes, why? _____
Reason for today's visit?
 Exam Emergency
 Consultation
Are you in pain? Yes No
How long? _____
Previous Dentist: _____
Approximate date of last dental visit? _____
Please indicate any of the following problems:
 Lost/Broken filling
 Dissatisfied with appearance of teeth
 Broken/chipped tooth
 Snoring
 Sleep apnea
 Clench/Grind teeth
 Clicking/Discomfort in jaw
 Sensitive teeth/gums
 Stained teeth
 Bad breath
 Missing teeth/Difficulty chewing
 Other
Is there anything you would like to inform the doctor about past/future dental treatment? _____

Medical Health History

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

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NAME: _____

DATE: _____

	yes	no
Heart Problems		
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve	<input type="checkbox"/>	<input type="checkbox"/>
Blood problems		
Easy bruising	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia)	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>
Allergy problems		
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems		
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>
Special diet	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint problems		
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement (e.g. total hip, pins, implants)	<input type="checkbox"/>	<input type="checkbox"/>
date of joint replacement: _____		
Fainting spells, Seizures, or Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Strokes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
If yes, please circle which type:	Type I/Type II	
Tuberculosis or other respiratory disease	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you chew tobacco?	<input type="checkbox"/>	<input type="checkbox"/>

	yes	no
Do you smoke?	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice or liver trouble	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury?	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	<input type="checkbox"/>	<input type="checkbox"/>
If so, please describe: _____		
LIST OF CURRENT MEDICATIONS: _____		

Have you ever been treated for osteoporosis with oral/IV medications? (bisphosphonates)	<input type="checkbox"/>	<input type="checkbox"/>
If yes, which kind and for how long? _____		
During the past 12 months, have you taken any of the following?		
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g. Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drugs/supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Are you allergic, or have you reacted adversely, to any of the following?		
Local anesthetics (novocaine)	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex	<input type="checkbox"/>	<input type="checkbox"/>
Nuts	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		
Women		
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date: _____		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>



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*We invite you to discuss with us any questions regarding our services.
The best dental health services are based on mutual respect between provider and patient.*

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ Date: ___/___/___

Acknowledgment of Receipt of Notice of Privacy Policies

I, _____, have seen a copy of this office's privacy policies.

Print name _____

Address _____

City _____

List family members who are also patients: _____

List person(s) you authorize to receive information regarding treatment and billing: _____



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Notice of Privacy Practices

Our promise:

This is not meant to alarm you, quite the opposite. It is our desire to communicate to you that the new Federal (HIPAA-Health Insurance Portability Accountability Act) laws, written to protect the confidentiality of your health information, are something we take seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily released to others outside our office.

So what has changed? Why a Privacy Policy now?

The most significant variable that has motivated the federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers, but also how it's used with the internet, telephone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere that it is used.

We want you to know about these policies and procedures, which we developed to make sure your health information will not be shared with anyone that does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your health information only for purposes of providing your treatment, obtaining payment, and conducting healthcare operations. Your health information will not be used for other purposes unless we have asked for, and been voluntarily given, permission.

How your health information may be used:

To provide treatment:

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies, or other health care personnel providing you treatment.

To obtain payment

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To conduct health care operations

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. Consequently, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed to audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

Patient reminders

Because we believe regular care is important to your oral and general health, we will remind you of a scheduled appointment or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of collaborating with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders, text messages, or emails, unless you tell us that you do not want these reminders.

Abuse or neglect

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specially required or authorized by law or with the patient's agreement.

Public health and national security

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public health or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical service.



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For law enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances, if you are a victim of a crime, or in order to report a crime.

Family, friends, and caregivers

We may share your health information with those you tell us that will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to use or disclose health information

Other than is stated above or where federal, state, or local law requires us, we will not disclose your health information other than with your authorization in writing at any time.

Patients' rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preference from our patients.

Confidential communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and copy your health information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your health information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of health information

You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the period for which you are interested. Thank you for limiting your request to no more than 6 years at a time. We may need to charge you a reasonable fee for your request.

Request a paper copy of this notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email you a copy.

We are required by law to maintain the privacy of your health information and to provide you and your representatives this Notice of our Privacy Practices. While we are required to practice the policies and procedures described in this notice, we do reserve the right to change the terms of our notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know your concern or complaints in writing.