Welcome to Stonebriar Smile Design. It is our pleasure that you have chosen our practice to care for your oral health. In our office, you will experience the subtle differences and team dentistry at its finest. We are delighted to share the highest quality of equipment and materials that will provide you the best dental care possible. Dr. Jill Wade, Dr. Kristi Moody & Dr. Jodi Danna and valued team members strive to provide you superior dental care, in a warm and caring environment.

During your appointment, we will gather a variety of detailed diagnostic data. This includes an oral cancer screening, evaluation of your periodontal health, necessary radiographs, and intra-oral images that reveal detailed information about not only your teeth but your oral tissues. All this data is evaluated to derive the most comprehensive treatment plan for you to maintain optimal oral health.

We now know there is compelling evidence to suggest a link with your oral/periodontal health and many systemic health diseases such as, cardiovascular disease, diabetes, and chronic inflammatory diseases. This emerging evidence makes it vital that you provide our office with a detailed medical history.

We focus on specific goals you have for your mouth, teeth, smile, and overall health in order to customize a treatment plan just for you. Be thinking about what goals you have, therefore, when we ask your expectations, you can share them with us.

- New patient comprehensive dental experience, 2 hours
- Please allow 48 hours' notice for schedule changes
- We encourage you to return the new patient packet 1 week prior to your scheduled appointment, so our team can be fully prepared for you.

We look forward to exploring and achieving your goals. For more information about our practice, please visit our website at www.stonebriarsmiledesign.com.

Sincerely,
Jill Wade, DDS, MAGD
Kristi Moody, DDS
Jodi Danna, DDS, FAGD

Child New Patient | Stonebriar Smile Design
Jill Wade DDS, MAGD | Kristi Moody DDS | Jodi Danna DDS, FAGD

Patient Name: _____Birth Date:_____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Guarantor Name:_____Relationship to patient:_____
Guarantor Phone: Home: _____Work: _____Cell:_____
Email: _____
Best method to confirm appointments: ☐ Phone: _____ ☐ Text ☐ Email

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EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____Phone: _____

INSURANCE INFORMATION

Current Insurance Carrier: _____ Employer: _____
Member Name: _____ Subscriber ID #: _____ SS#: _____
Group #: _____ Insurance Phone #: _____
Relationship of member to patient:_____

HEALTH INFORMATION

List any and all **ALLERGIES:** _____

List any and all **DRUGS/MEDICATIONS** the patient is taking: _____
_____

List any and all **SURGERIES**: _____

Patient's Physician:_____ Phone:_____

Is patient currently being treated by a physician? ☐Yes ☐No
Please explain _____

Is patient in good health	☐ Yes	☐ No	Clenching/Grinding/TMJ	☐ Yes	☐ No
Abnormal Bleeding	☐ Yes	☐ No	Asthma	☐ Yes	☐ No
Joint/Knee Replacement	☐ Yes	☐ No	Acid Reflux/Indigestion	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Stomach Problems/Ulcers	☐ Yes	☐ No
Cancer/Chemo/Radiation	☐ Yes	☐ No	Kidney/Liver Conditions	☐ Yes	☐ No
HIV/AIDS/Hepatitis	☐ Yes	☐ No	Convulsions/Epilepsy	☐ Yes	☐ No
MVP/Heart Disease/ Murmur	☐ Yes	☐ No	Congenital Heart Disease	☐ Yes	☐ No
Headaches/Migraines	☐ Yes	☐ No	Disabilities	☐ Yes	☐ No

Does the patient require dental pre-medication due to a specific condition such as joint/valve replacement, cardiovascular condition, etc.? ☐Yes ☐No
If yes, has it been taken as prescribed? ☐ Yes ☐ No

DENTAL HISTORY

Please describe the main reason for the consultation/new patient appointment with Dr. Wade

_____

_____

When was the patients last: dental exam?_____Cleaning?_____ X-rays?_____

Please share any concerns about treatment, timing, finances or anxiety?_____

_____

Have there been any injuries to the teeth, face or mouth? ☐Yes ☐No

If yes, please explain:_____

Is the patient's water fluoridated? ☐Yes ☐No
Is the patient taking fluoride supplements? ☐Yes ☐No
Does the patient brush their teeth daily? ☐Yes ☐No
Does the patient floss their teeth daily? ☐Yes ☐No

DOES THE PATIENT HAVE ANY OF THE FOLLOWING?

Discolored / Dark Teeth	☐ Yes	☐ No	Chipped / Thin Teeth	☐ Yes	☐ No
Clenching / Grinding / TMJ	☐ Yes	☐ No	Spaces between Teeth	☐ Yes	☐ No
Crowded / Crooked Teeth	☐ Yes	☐ No	Orthodontic Treatment	☐ Yes	☐ No
Red / Swollen / Bleeding Gums	☐ Yes	☐ No	Anxiety with Dental Work	☐ Yes	☐ No
Lip Sucking / Biting	☐ Yes	☐ No	Nail Biting	☐ Yes	☐ No
Thumb / Finger Sucking	☐ Yes	☐ No	Tonsils / Adenoids	☐ Yes	☐ No
Walk / Talk in Sleep	☐ Yes	☐ No	Snoring	☐ Yes	☐ No
Bed Thrasher	☐ Yes	☐ No	Strep Throat Recurrence	☐ Yes	☐ No
Sinus Infection	☐ Yes	☐ No	Ear Infections	☐ Yes	☐ No
ADD / ADHD	☐ Yes	☐ No	Wetting Bed	☐ Yes	☐ No
Hyperactive	☐ Yes	☐ No	Dark Circles under Eyes	☐ Yes	☐ No

Signature: _____ Date: _____

Dental Treatment & Information Acceptance Form
Stonebriar Smile Design

Please initial each section.

___ **HEALTH INFORMATION**

I agree to disclose ALL previous illnesses, medications; medical, dental, and family history. Any undisclosed information or omissions could have a negative effect on my dental and oral health. I have been informed there are oral-systemic links that can affect my overall wellness.

___ **DRUGS, LATEX AND MEDICATIONS**

I understand that antibiotics and other medications can cause allergic reactions and/or anaphylaxis, which is potentially a life-threatening condition that can interfere with normal breathing. Latex allergies can cause rashes and itching. Epinephrine, which is used in some dental injections, increases heartbeat, and depending on my health status may be dangerous. Please, disclose any information on our health history forms pertaining to any known drug or latex allergies.

___ **DENTAL TREATMENT**

I authorize Stonebriar Smile Design to take radiographs, study models, photographs, and any other diagnostic aids deemed appropriate to my oral health needs. I also authorize Dr. Jill Wade, Dr. Kristi Moody & Dr. Jodi Danna to prescribe any forms of medication and perform any therapy that may be indicated and agreed upon. It is possible that a tooth may require endodontic treatment (root canal), even after a filling or a crown is done depending on the depth of existing restoration or decay present. This is not always predictable from radiographs alone. I also understand that if my teeth are sensitive after treatment, I must contact the office for an appointment to adjust my bite.

___ **PORCELAIN CROWNS / VENEERS / BONDING & COSMETIC FILLINGS**

Once a crown, veneer, bonding or filling is placed, I understand the color cannot be changed without a remake. I have been counseled, informed and educated on how important it is to maintain a healthy balanced dental regimen achieved by complying with hygiene and dental treatment plans set out by Dr. Wade, Dr. Moody & Dr. Danna. I understand that many factors contribute to my oral health: stress, clenching, grinding, acidity, diet and genetics. I am aware that most people grind their teeth subconsciously, which is damaging to the teeth and can break teeth or dental restorations. I have been informed about the need to wear an occlusal guard for protection, and a bite check is suggested.

___ **PHOTOGRAPHY RELEASE**

I understand that photographs, x-rays, and videos will be used as a record of my care, and may be used for educational purposes in lectures, demonstrations, advertising, and professional publications.

___ **HYGIENE THERAPY**

I understand that upon diagnosis of periodontal disease, I no longer fall under the category of a "routine" dental cleaning. The treatment is then categorized under the periodontal dental procedure codes which require additional services than "routine" cleanings. Bleeding gums and family history will contribute to this diagnosis.

___ **HYGIENE APPOINTMENTS**

If I am more than 15 minutes late for my professional dental cleaning, I will either accept what treatment can be rendered in the remaining time, meaning a compromised dental appointment, or will reschedule and pay the $150.00 broken appointment fee.

___ **LIMITATION OF INSURANCE COVERAGE**

STONEBRIAR SMILE DESIGN IS NOT AN IN NETWORK PROVIDER FOR ANY INSURANCE COMPANY. This means I am responsible for the difference in what insurance pays for my services and the cost of my treatment. As a courtesy, Stonebriar Smile Design will file my dental insurance claims. Most insurance companies will allow assignment of benefits payable directly to the office, meaning that I only pay the **ESTIMATED** portion at the time of service. However, the portions collected are only an ESTIMATE, once my insurance claims clear there may still be a balance due. I agree to be financially responsible for what insurance does not cover.

___ **48 HOUR NOTICE OF CANCELLATION**

I agree to give 48 hours' notice for schedule changes or I will be subject to pay the broken appointment fee of $150.00. I understand that leaving a message after hours before my appointment is NOT sufficient notice. We do realize there can be extenuating circumstances.

___ **APPOINTMENT TIMES & EMERGENCY CARE**

I grant permission for contacting me via telephone (work, home, or cell), email, or text to discuss matters related to my treatment, accounting, or dental appointments. It is our philosophy to be available to any patient in discomfort, or in an emergency situation. This courtesy is extended to all patients and we ask for your cooperation to only use the emergency contact line for true emergencies, such as, a broken tooth or severe dental infection causing swelling and pain.

___ **FINANCIAL POLICIES & HIPAA**

I have received and understand the financial policies of Stonebriar Smile Design. I am aware they follow protocol of HIPAA'S notice of privacy laws.

Name: _____ Date: _____

STONEBRIAR SMILE DESIGN

FINANCIAL OPTIONS AND DENTAL INSURANCE

PAYMENT IN FULL OPTION

_____ **I prefer to PAY IN FULL and acknowledge that my claim will be filed on my behalf. Any insurance benefits will be mailed directly to me by my insurance.**
The reimbursement process typically takes 2-4 weeks. Knowledge of insurance limitations and frequencies are the responsibility of the insured.

$_____ Payment at time of service with cash, check, or credit
$_____ Care Credit, the entire fee will be applied and insurance reimbursement will be mailed directly to you.
2 forms of ID required for Care Credit

DENTAL INSURANCE OPTION

_____ **Please file my dental insurance on my behalf and I will pay my estimated out-of-pocket portion at the time of service. $_____any remaining balance may be applied to the following card.** This option ***Requires*** a credit-card on file.

***** Delta Dental, United Concordia, Humana or Blue Cross Blue Shield patients will select Option 1 as these policies reimburse the insured.**

Patient Name: _____ Use this card for entire Family?_____

Cardholder Name:_____

Card Type: ❒ VISA ❒ MC ❒ AM EX ❒ DISCOVER ❒ CARE CREDIT

Card Number:_____

Expiration Date: _____ CVV Code: _____ **VAULTED**_____

_____ I have been presented all treatment plan options.
_____ I have been presented with all my financial options.
_____ I understand I am not obligated to move forward with treatment.

_____

Signature Date Practice Signature

We are committed to providing you the best possible care available.
Our office is **an out-of-network provider for ALL insurance plans** due to the limitations they attach to treatment, regardless of the diagnosis.
Treatment plan fees are guaranteed for 90 days.

STONEBRIAR
SMILE DESIGN

Acknowledgement of Receipt
Consent to Use and Disclosure of Protected Health Information

Notice of Privacy Practices
Review our Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. You may choose to review the Notice prior to signing this consent. By signing below, you acknowledge that we have given you a copy of our Notice of Privacy Practices.

Use and Disclosure of your Protected Health Information
Your Protected Health Information will be used by our practice or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Requesting a Restriction on the Use or Disclosure of Your Information
You may request a restriction on the use or disclosure of your Protected Health Information.
Our office may or may not agree to restrict the use or disclosure of your Protected Health Information.
If we agree to your request, the restriction will be binding with our office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of Federal privacy standards.

Revocation of Consent
You may revoke this consent to the use and disclosure of your Protected Health Information. However, you must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name

Witness Signature

Date Time

STONEBRIAR
SMILE DESIGN

Patient Authorization
Release of Protected Health Information Records

Information to Be Released

Information covered by this authorization includes: _____

_____

Release of Records

The information listed above will be released to:

_____

Name of person, organization and address or fax number to which records should be sent - Please double-check fax number for accuracy

_____

Purpose of this Release

☐ For treatment at the facility to which records are sent ☐ Other reason _____

The Protected Health Information specified in this Release will be used solely for the purposes of treatment, payment and healthcare operations. Our facility complies with all applicable Federal and State privacy laws.

By my signature below I give permission to release the specified information.

Patient or Legally Authorized Individual Signature

Date Time

Print Patient's Full Name _____

Witness Signature

Date Time