STONEBRIAR
SMILE DESIGN

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. The Doctors and our 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,
Your Stonebriar Smile Design Team

Welcome to Stonebriar Smile Design

PATIENT INFORMATON

Patient Name: _____ Birth Date: _____ Age: _____ SS #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work: _____ Cell: _____ Email: _____
Gender: ☐ M ☐ F How did you hear about us? _____
Emergency Contact Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Name of Insured: _____ Insured's Birth Date: _____ Is insured a patient? ☐Yes ☐No
Subscriber ID #: _____ SS#: _____
Insured's Employer Name: _____
Insurance Company: _____ Group Number: _____ Phone: _____
Insurance Claims Mailing Address: _____

Please describe the main reason for your consultation/new patient appointment with Stonebriar Smile Design
(How long has this issue been going on & what other past events apply?)_____

_____

Preferred Pharmacy : Medical Doctor name

Please rate your smile. Dislike☐1 ☐2 ☐3 ☐ 4☐ 5☐ 6 ☐7 ☐8 ☐ 9 ☐10 Satisfied

When was your last dental examination? _____ Cleaning? _____ X-rays? _____

Current home care: **Brush:** Manual or Electric **How often?**_____ **Floss:** ☐Daily ☐Occasionally ☐Rarely

Circle previous dental procedures experienced: ☐Whitening Take-home trays/Zoom in-office
Night guard/retainers☐ Cosmetic veneers/crowns☐ Implants☐ Ortho/Invisalign☐

PLEASE RATE THE IMPORTANCE OF THE FOLLOWING GOALS.

Optimal Preventative Care (proactive approach to underlying problems, preventing issues before they arise)
Not important 1☐ 2☐ 3☐ 4☐ 5☐ Extremely Important _____

Optimal Restorative Care (removing old metal fillings, cavity prevention products, protecting dental work)
Not important 1☐ 2☐ 3☐ 4☐ 5☐ Extremely Important _____

Cosmetic Options (Invisalign, whitening, porcelain veneers, anti-aging)
Not important 1☐ 2☐ 3☐ 4☐ 5☐ Extremely Important _____

Dental Wellness Approach (sleep apnea/snore device, Oral DNA testing/heart disease, nutritional recommendations)
Not important 1☐ 2☐ 3☐ 4☐ 5☐ Extremely Important _____

Please share your individual dental goals. _____

_____

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

_____

DO YOU HAVE ANY OF THE FOLLOWING?

Discolored or dark teeth?	☐Yes	☐No	Chipped, thin, or worn down teeth?	☐Yes	☐No
Old unsightly crowns with black lines?	☐Yes	☐No	Clenching or grinding your teeth?	☐Yes	☐No
Spaces between your teeth?	☐Yes	☐No	TMJ, jaw, or muscle soreness?	☐Yes	☐No
Crowded or crooked teeth?	☐Yes	☐No	Frequent headaches or migraines?	☐Yes	☐No
History of orthodontic treatment?	☐Yes	☐No	Do you have a night guard/NTI?	☐Yes	☐No
Any history of gum disease?	☐Yes	☐No	Cover your mouth when you smile?	☐Yes	☐No
Red, swollen, bleeding or receding gums?	☐Yes	☐No	Anxiety with dental work?	☐Yes	☐No

Initials _____ Date _____

HORMONES

WOMEN ONLY

Menopause: _____
Premenopause: _____
Duration of Flow: _____
Flow: Heavy ☐ Light ☐
Last Papsmear: _____
Contraception: _____
Pregnant ☐ Nursing ☐
Pregnancy: _____
Births: _____
Hysterectomy Age:
Partial ☐ Full ☐
Last Mammogram: _____

☐Hormone Replacement
☐Hot Flashes
☐Decreased Libido
☐Pre-Menstrual Syndrome
☐Irregular Period

MEN ONLY

☐Steroid Supplements
☐Hormone Replacement
☐Decreased Libido
☐Prostate Inflammation
Last Prostate Exam:
_____

Have you experienced trouble with :

☐Ovaries
☐Thyroid
☐Adrenals
☐Pituitary
☐Dizzy Spells
☐Swollen Lymphnodes
☐Hot Intolerance
☐Cold Intolerance
☐Bladder Incontinence/Urgency
☐Exposure to Human Papilloma Virus

☐Depression
☐Poor Memory
☐Hair Loss
☐Mood Swings
☐Irritability
☐Foggy Thinking
☐Anxiety
☐Trouble Sleeping
☐Fatigue
☐Bone Loss
☐Osteoporosis
☐Taking Bisphosphonates

PURIFICATION

Please check all that apply

☐Elevated Cholesterol
☐Heart Palpitations
☐High Blood Pressure
☐Low Blood Pressure
☐Heart Murmur
☐Swollen Extremeties
☐Chest Pain/Pressure
☐Varicose Veins
☐Blood Clots
☐Abnormal Bleeding
☐Anemia
☐Low Blood Iron/Vitamin D
☐Bruise Easily
☐Rheumatic Fever
☐Congenital Heart Defect
☐Pacemaker/Artificial Valve
☐Mitral Valve Prolapse

☐Bronchitis
☐Pneumonia
☐Asthma
☐Lung Disese
☐Throat Soreness
☐Tonsils Removed
☐Hoarseness
☐Persistent Cough
☐Trouble Swallowing
☐Herpes
☐Shingles
☐HIV/Aids
☐Hepatitis
☐Appendix
☐Gall Bladder

☐Chemotherapy
☐Radiation
☐Bleeding Gums
☐Bad Breath
☐Existing Periodontal Disease
☐Gingivitis
☐Dental Infection
☐Ulcers/Blisters
☐Pre-Med for Dental Appt

FAMILY or SELF HISTORY:

Cardiovascular Disease

Stroke

Cancer

CURRENTLY UNDER CARE FOR THE FOLLOWING:

Dr. _____
Dr. _____
Dr. _____
_____

HOW MUCH /DAY:

Smoke: _____
Tobacco: _____
Alcohol: _____

Initials: _____ Date: _____

LIST MEDICATIONS (Rx & Over-the-counter**,** Dosage, Frequency**):**

CURRENT ANTIBIOTICS:

CURRENT SUPPLEMENTS/VITAMINS:

ALLERGIES:

FAMILY or SELF HISTORY:
Diabetes

NUTRITION

Please check all that apply:

- ☐Dry Skin
- ☐Hives/Rashes
- ☐Latex Allergy
- ☐Stomach Ulcers
- ☐Belching
- ☐Indigestion/Heartburn
- ☐Acid Reflux
- ☐Weight Gain/Loss
- ☐Bloated
- ☐Sugar Cravings
- ☐Lines/Roughness of Nails
- ☐Colitis
- ☐Nausea
- ☐Constipation
- ☐Irregular Bowel Movements
- ☐Diarrhea
- ☐Crohn's Disease
- ☐Alcohol Intolerance
- ☐Blood Sugar Imbalance
- ☐Insulin Dependent

Age: _____
Height: _____
Weight: _____
BMI: _____

Blood Type:
A +☐ A-☐ B+☐
B-☐ AB +☐ AB-☐
O+☐ O-☐ Not Sure☐
APO-E: _____

Have you experienced trouble with:

- ☐Muscle Tension/Soreness
- ☐Stressful Lifestyle
- ☐Eye Twitches
- ☐Dry Eyes
- ☐Immune Deficiency/Disease
- ☐Headaches/Migraines
- ☐Dry Mouth
- ☐Grinding/Clenching Teeth
- ☐Tooth Pain
- ☐Pop/Clicking of Jaw
- ☐TMJ Problems
- ☐Epilepsy/Seizures
- ☐ADD/ADHD
- ☐Back/Spine Degeneration
- ☐Joint Replacement
- ☐Arthritis
- ☐Fibromyalgia
- ☐Loss of Sensation
- ☐Auto Immune Disease
- ☐Lupus/Sjorgen's Syndrome
- ☐Sleep Apnea

FAMILY or SELF HISTORY:
Periodontal Disease

_____

Alzhiemer's Disease

_____

PAIN or TROUBLE WITH:

Neck: _____
Shoulder: _____
Back: _____
Joints: _____
Eyes: _____
Ears: _____
Nose: _____
Other: _____

LIST SURGERIES/INJURIES:

_____
_____
_____
_____

NERVOUS

Initials: _____ Date: _____

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 the providing Doctor 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 the providing Doctor. 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. Stonebriar Smile design has my authorization to run the card on file for the remaining balance.

___ **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

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