Drs. Bidinger and Stiles

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ______________________________, have received a copy of this office's Notice of Privacy Practices.

____
Please Print Name/ Patient

____
Signature/ Patient or Guardian

____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

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RONALD E. BIDINGER, D.D.S. • JEFFREY M. STILES, D.M.D.
14 CODY ST., WEBSTER, MA 01570
Telephone (508) 949-0002

▶ Patient Information

Name: ______________________ Sex (M) (F) Birthdate: ______________
Address: ______________________ Home Phone: ______________
City: ______________________ Work Phone: ______________
Social Security #: ______________________ Cell Phone: ______________
If Student Name of School/College: ______________________ Full Time Student: ______________
Name of Employer: ______________________
Employer Address: ______________________
____
Spouse or Parent (Guardian) Name: ______________________
Person to Contact in Case of Emergency: ______________________ Phone: ______________
Referred to this Office by: ______________________ Cell Phone: ______________
Check Appropriate Box: ☐ Minor ☐ Married ☐ Single

▶ Responsible Party

Name of Person Responsible for this Account: ______________________
Relationship to Patient: ______________________
Address: ______________________
____
Employer: ______________________
Home Phone: ______________________ Work Phone: ______________
Social Security #: ______________________ Cell Phone: ______________

▶ Insurance Information

Name of Insured: ______________________ Relationship to Patient: ______________
Birthdate: ______________________ Social Security #: ______________
Name of Employer: ______________________
Employer Address: ______________________
Insurance Company: ______________________ Group #: ______________
Insurance Company Address: ______________________ ID #: ______________
____
Deductible Amount: ______________________ Max Annual Benefit: ______________

Do You Have Additional Dental Insurance? ☐ Yes ☐ No If yes, complete below.

Name of Insured: ______________________ Relationship to Patient: ______________
Birthdate: ______________________ Social Security #: ______________
Name of Employer: ______________________
Employer Address: ______________________
Insurance Company: ______________________ Group #: ______________
Insurance Company Address: ______________________ ID #: ______________
____
Deductible Amount: ______________________ Max. Annual Benefit: ______________

Patient Medical History

Physican: ________________________ Phone: ____________

Address: ________________________

____

1. Are you presently under medical treatment? ☐ Yes ☐ No With whom? ____________
2. Are you taking any medications? ☐ Yes ☐ No Which medications? ____________

____

3. Do you use: Alcohol ☐ Yes ☐ No Tobacco ☐ Yes ☐ No Other "Recreational" Drugs? ☐ Yes ☐ No
4. Do you have any allergies? If so, to what? ____________

____

5. Do you have or have you had any serious illness? ____________

____

6. Are you: ☐ Pregnant ☐ Nursing ☐ Taking Birth Control Pills?
7. Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
Heart Valve Replacement	☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐
Joint Replacement	☐	☐	Angina	☐	☐	Aids or HIV Infection	☐	☐
Radiation Therapy	☐	☐	Heart Disease	☐	☐	Seizures/Fainting	☐	☐
Heart Murmur	☐	☐	Liver Disease	☐	☐	Psychiatric Disorder	☐	☐
Rheumatic Fever	☐	☐	Kidney Disease	☐	☐	Diabetes	☐	☐
Hepatitis	☐	☐	Respiratory Problems	☐	☐	Other Chronic Ailment	☐	☐

Comments: ________________________

____

____

____

Patient Dental History

	Yes	No
Do your gums bleed while brushing?	☐	☐
Are your teeth sensitive to hot or cold?	☐	☐
Do you have any sores or lumps in your mouth?	☐	☐
Have you had previous joint injuries?	☐	☐

	Yes	No
Do you clench or grind your teeth?	☐	☐
Have you ever had Orthodontic Treatment?	☐	☐

If yes, by whom? ____________

Last x-rays? ____________

When was your last visit to a dentist? ____________

Reason for today's visit? ____________

Authorization & Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on me and my dependents.

X ________________________ Date ____________

I consent to Drs.' Bidinger and Stiles to use my cell phone number to call or text regarding appointments, treatment, insurance or account. I can withdraw my consent at any time. I have read the above information. This has been explained to me to my satisfaction and I agree to the policy.

X ________________________ Date ____________

DENTAL TREATMENT CONSENT FORM

Please read and initial the items checked below and read and sign the bottom of the form.

1. WORK TO BE DONE
I understand that I am having the following work done: Fillings_______Other_________Initials____________

2. DRUGS AND MEDICATIONS
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). Initials__________

3. CHANGES IN TREATMENT PLAN
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
Initials______

4. Dr. Bidinger and Dr.Stiles or any attending hygienist have my permission to perform prophylaxis, fluoride treatment, x-rays, and any/all exams on myself and/or my dependents until that permission is revoked by me in writing by certified mail addressed to this office. Initials______

5. I have read the above information. This has been explained to me to my satisfaction and I agree to the proposed treatment plan.

______________________________	____________________	__________________________________
Patient Signature	Date	Print Name Patient
______________________________	____________________	
Dentist Signature	Date	
______________________________	____________________	
Witness Signature	Date	