Greg Steiner D.D.S.

1550 N. Crestmont Dr. Suite C
Meridian, Idaho 83642

Patient Demographic Information

Marital Status
- ☐ Single/Child
- ☐ Married
- ☐ Separated/Divorced

Preferred Language
- ☐ English
- ☐ Spanish
- ☐ Other: ___________

Patient: ____
(Last) (First) (MI)

Date of Birth ______________________ Gender: M / F SSN: ______________________

Address: ____
(Street) (City) (State) (ZIP)

Home: ______________________ Mobile: ______________________

Other: ______________________ Email: ______________________

Whom may we thank for referring you?: ______________________

Parent/Guarantor Name and phone number: ______________________Relation: ___________

Emergency contact name and phone number: ______________________ Relation: ___________

Billing Information (medical insurance card, front & back must be submitted as attachment)

☐ No insurance, self-pay

☐ Dental Insurance & Phone Number: ______________________

Policy Holder & Date of birth: ______________________ ID Number: ______________________

☐ Medical Insurance & Phone Number: ______________________

Please Read and Initial Each Statement

________Assignment of Benefits: I hereby assign all applicable insurance benefits and direct that payment be made directly to Greg Steiner D.D.S.

_______Release of Information: I authorize Dr. Steiner to furnish medical and other information necessary to process insurance claims on my behalf. This information may be released to my personal physician and, upon request, to any other healthcare provider who may need the information for continuity of care.

_______Financial Responsibility: I have read and understand the full financial policy. I understand and agree that I am responsible for payment on all charges including those not paid by my insurance at the time of service. If I fail to make payment arrangements or payment in full for services that are rendered to me within 90 days of the date of service, my outstanding balance will be sent to a collection's agency. I will be responsible for the fees assessed by the collection's agency.

_______Treatment Authorization: I am willfully requesting treatment and consent to services provided by, or at the direction of the attending provider at Greg Steiner D.D.S. I authorize a copy of this document to be used in lieu of the original.

_______Notice of Privacy Practices: I have received a copy of PRACTICE's Notice of Privacy Practices on this or a prior occasion. I have fully read, understand, and agree to this Consent and Conditions of Treatment. I certify that I am either the Patient or the Patient's legally authorized representative and have authority to execute this Consent and Agreement on behalf of Patient. I have had the opportunity to ask questions concerning this Consent and Conditions of Treatment and have had my questions answered to my satisfaction.

$35.00 Cancellation fee will be assessed if you No Show or fail to give 48 hour notice of cancellation

Name: ______________________ Address: ______________________ Phone Number: ______________________

______________________________________ ______________________

Signature of Patient or Legal Guardian **Date Signed**

(If not patient): Printed Name ______________________ **Relationship to Patient:** ______________________

*For Dr Use Only

ASA 1 2 3 4

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Health Questionnaire

Please carefully answer the following questions.

Patient Name: ______________________ Physician's Name______________________
Date of Last Visit ____________

Environmental/ Medication Allergies and Reaction:

____

____

Previous History of Surgeries and Year:

____

____

Have you ever had or currently have?

Yes ___ No___ Abnormal bleeding during extractions or surgery	Yes ___ No___ Arthritis
Yes ___ No___ Latex allergy	Yes ___ No___ Tuberculosis
Yes ___ No___ Cancer	Yes ___ No___ Rheumatic Fever
Yes ___ No___ Chemotherapy, radiation	Yes ___ No___ Anemia or blood disorders
Yes ___ No___ Heart conditions, chest pain, palpitations, puffs	Yes ___ No___ Kidney problems
Yes ___ No___ Pacemaker	Yes ___ No___ Hepatitis or liver disease
Yes ___ No___ High blood pressure	Yes ___ No___ Skin rashes or problems
Yes ___ No___ Low blood pressure	Yes ___ No___ Chemical Dependency
Yes ___ No___ Stroke or transient ischemic attack (TIA)	Yes ___ No___ Bruise, bleed easily
Yes ___ No___ Seizures, epilepsy, neurological issues	Yes ___ No___ Blood clotting issues
Yes ___ No___ Sleep apnea	Yes ___ No___ Blackouts or dizziness spells
Yes ___ No___ Are you under a physician's care for sleep Apnea and/or wear a CPAP	Yes ___ No___ HIV/AIDS
Yes ___ No___ Immune system disorder	Yes ___ No___ Pregnant, or could be pregnant (female patients)
Yes ___ No___ Lung or breathing problems/Asthma	Yes ___ No___ Recent illness affecting upper airways/throat
Yes ___ No___ Diabetes, thyroid issues	Yes ___ No___ Artificial joints or replacements/Premed
Yes ___ No___ Heartburn, GERD, reflux	Yes ___ No___ Tobacco use
Yes ___ No___ History of a blood transfusion	Yes ___ No___ Alcoholic beverages
Yes ___ No___ Headaches	Yes ___ No___ Personal/family history of adverse reactions to anesthesia
Yes ___ No___ Jaw Pain	Yes ___ No___ I am interested in information about orthodontics/Clear Braces
Yes ___ No___ Thyroid Issues	
Yes ___ No ___ Have you ever used/currently using a bisphosphonate medication? (Fosamax, Prolia, etc)	

Please explain if you have answered yes to any answer:

____

____

Are you currently being treated for any chronic conditions by a physician? Yes, please explain / No

____

____

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Health Questionnaire: List of Medications

Please carefully answer the following questions.

Is this patient currently taking any medications?

- ☐ Yes, fill in below and sign bottom of page. If a list is being provided please attach it with the submission of this paperwork.
- ☐ No, sign bottom of page.

Prescribed Medication	Dose	How Often	Route Taken
Over-the-Counter Medication	Dose	How Often	Route Taken
Vitamins/Herbal Medication	Dose	How Often	Route Taken

______________________________ **Signature of Patient or Legal Guardian**

______________________________ **Date Signed**

(If not patient): Printed Name ______________________________ **Relationship to Patient:** ______________