WELCOME

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name_____Soc. Sec.#_____
Last Name First Name Initial

Address_____

City_____State_____Zip_____

Home Phone_____Cell Phone_____

Business Phone_____

Sex____M_____F Age_____Birthdate_____

Single__ Married___ Widowed___ Separated___ Divorced_____

Patient Employed by_____Occupation_____

Business Address_____Business Phone_____

Whom may we thank for referring you?_____

Whom may we call in case of emergency (or notification of

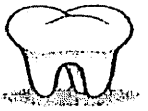
Cancellation)?_____Phone_____

AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. Payment is due in full at time of treatment, unless prior arrangements have been approved or procedures have been submitted to insurance. I understand that a 1.33% finance charge will be assessed monthly for any account balance remaining over 60 days. I agree to reimburse the office the fees of any collection agency, which may be based on a percentage at a maximum of 50% of the debt, and all costs, and expenses, including reasonable attorneys' fees, the office incurs in such collection efforts

.

Signature_____Date_____



CHILD'S DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO THE DENTIST? _____

IF THE ANSWER IS NO, PLEASE ENTER THE DATE OF YOUR CHILDS LAST EXAM_____

PLEASE INCLUDE THE NAME, ADDRESS AND PHONE NUMBER OF THE FORMER DENTIST

_____

HOW OFTEN DOES YOUR CHILD BRUSH?_____

HOW OFTEN DOES YOUR CHILD FLOSS?_____

DOES YOUR CHILD HAVE RECENT DENTAL X-RAYS?_____

PLEASE CHECK ALL THAT APPLY TO YOUR CHILD:
_____THUMB/FINGER SUCKING _____FINGERNAIL BITING _____GRINDING TEETH
_____LIP OR CHEEK BITING _____JAW DIFFICULTY: CLICKING AND OR PAIN IN JAW
_____ORTHODONTIC TREATMENT

CHILD'S HEALTH HISTORY

Please check all that apply to your child:

_____ ALLERGIES _____ EPILEPSY _____ SCARLET FEVER _____HIV/AIDS

_____ ANEMIA _____ ASTHMA _____CANCER _____DIABETES

_____HEART MURMUR _____HEPATITIS-TYPE _____RHEUMATIC FEVER

_____SCARLET FEVER _____TONSILLITIS _____TUBERCULOSIS

ARE THERE ANY OTHER HEALTH CONDITIONS THE DOCTOR SCHOULD BE AWARE OF? IF SO, PLEASE EXPLAIN_____

CHILD'S NAME_____

CHILD'S ADDRESS_____

CHILD'S BIRTHDATE_____ CHILD'S SS# _____ FEMALE____ MALE_____

PARENT OR GUARDIAN NAME_____ PHONE_____ CELL_____

AUTHORIZATION

I HAVE REVIEWED THE INFORMATION ON THIS QUESTIONAIRE, AND IT IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. PAYMENT IS DUE IN FULL AT TIME OF TREATMENT, UNLESS PRIOR ARRANGEMENTS HAVE BEEN APPROVED OR PROCEDURES HAVE BEEN SUBMITTED TO INSURANCE. I UNDERSTAND THAT A 2% FINANCE CHARGE WILL BE ASSESSED MONTHLY FOR ANY ACCOUNT BALANCE REMAINING OVER 60 DAYS.

SIGNATURE PARENT/GUARDIAN _____ DATE_____

STIRLING SMILES
BRIDGET A. LANG, DMD, LLC

AUTHORIZATION TO DISCLOSE DENTAL/MEDICAL/FINANCIAL INFORMATION

- I authorize release of my patient health information to any and all physicians/dentists/ dental specialists, when deemed appropriate for my care.

SIGNATURE OF PATIENT OR REPRESENTATIVE_____
DATE_____

- I hereby authorize Dr. Bridget Lang and the office staff to share my treatment, diagnosis, and billing/payment information with the following individuals:

NAME_____

RELATIONSHIP_____PHONE_____

NAME_____

RELATIONSHIP_____PHONE_____

SIGNATURE OF PATIENT OR REPRESENTATIVE_____
DATE_____

= OR =

- I do NOT wish to share my treatment, diagnosis or financial data with any third party.

SIGNATURE OF PATIENT OR REPRESENTATIVE_____
DATE_____

STIRLING SMILES
BRIDGET A. LANG, DMD, LLC

ACKNOWLEDGEMENT OF RECEIPT 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_____

Signature_____

Date_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices. No acknowledgement could be obtained because:

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

_____

_____

_____

STIRLING SMILES
BRIDGET A. LANG, DMD, LLC

INSURANCE AUTHORIZATION

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 behalf of myself or my dependents.

_____
Signature of responsible party

_____
Date

PRIMARY DENTAL INSURANCE

Person Responsible for Account_____
Last Name *First Name* *Initial*
Relationship to patient_____Birthdate_____Soc.Sec#_____

Address (if different from patient)_____

Home Phone_____Cell_____Business_____

Person Responsible Employed by_____ Occupation_____

Business Address _____ Business Phone_____

Insurance Company_____ Phone_____
Insurance Address _____
Contract #_____ Group #_____ Subscriber # _____

Name of other dependents under this plan _____

ADDITIONAL DENTAL INSURANCE

Is patient covered by additional insurance? Yes_____ No_____
Subscriber Name_____ Relation to Patient _____ Birthdate_____
Address (if different from patient)_____ Soc. Sec #_____
Subscriber Employed by_____ Business Phone_____
Insurance Company_____ Phone_____
Insurance Address _____
Contract #_____ Group #_____ Subscriber #_____
Name of dependents under this plan_____

I understand if the Dental Practitioner does not participate in my plan;
I am responsible for the balance not paid under my insurance
coverage_____
Signature