

# Stephanie L Hirt, DMD

**Patient ID:**  
**Date:**

This packet was completed without the patient verifying themselves. Please review it carefully. We recommend reviewing the information with the patient at their appointment before making changes to the patient's record in your system.

## Demographic Information

**First Name:** \_\_\_\_\_

**Middle Name:** \_\_\_\_\_

**Last Name:** \_\_\_\_\_

**Gender:**

**Birthdate:** Preferred

**Race:**

**Language:**

**Ethnicity:**

**Address 1:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State/Province:** \_\_\_\_\_

**Address 2:** \_\_\_\_\_

**Zip Code/Postal Code:** \_\_\_\_\_

## Insurance Information

**Billing Priority:** Primary

**Company:**

**Plan:**

**Policy/Group Number:**

**Insurance/Member Id Number:**

**Insurance Provider Phone:**

**Insured Name:**

**Insured Birthdate:**

**Patron's Relation to Insured:**

## Contact Information

**Preferred Contact Method**      **Cell Phone** \_\_\_\_\_

**Email Address** \_\_\_\_\_

**Emergency Contact Name:** \_\_\_\_\_

**Emergency Contact Phone:** \_\_\_\_\_

**Relation to Patient:** \_\_\_\_\_

## Employer Information

**Employer:**

**How long with current employer:**

**Occupation:** Data Analytics

**Address 1:**

**Zip:**

**Address 2:**

**State:**

**City:**

## Other Information

**Referred By:**

**Primary Physician:**

**How did you find us?:**

**Drivers License:**

## Consent to Treat Form: \_\_\_\_\_

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I give permission for Dr. Stephanie Hirt DMD to give me medical treatment.

I allow Dr. Stephanie Hirt DMD to file for insurance benefits to pay for the care I receive.

I understand that:

- Stephanie Hirt DMD will have to send my medical record information to my insurance company.
- I must pay my share of the costs.
- I must pay for the cost of these services if my insurance does not pay or I do not have insurance.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

**Signature:** \_\_\_\_\_

You represent and warrant that the individual electronically agreeing to the terms of this Agreement is authorized and empowered to agree to this Agreement on your behalf. You further agree that checking a box to acknowledge your assent to this Agreement and/or clicking the "AGREE" button and/or performing any other similar electronic affirmation constitutes an electronic signature as defined by the Electronic Signatures in Global and National Commerce Act and that this Agreement is completely valid, has legal effect, is enforceable, and is binding on and non-refutable by you.

## Financial Agreement

Thank you for choosing Dr. Stephanie Hirt DMD.

Please take a moment to read the following, initial each section and sign and date the bottom of this form.

**If applicable**, insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances that are not paid within X days may be billed to you. Please keep statements and follow-up with your insurance carrier to ensure prompt payment. Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to keep your appointment may result in a charge for the time reserved, as this time could be given to another patient in need.

It is required to confirm an appointment with a specialist at least 48 hours in advance. If a 48-hour notice is not given, a cancellation fee of a minimum \$50 will apply.

There will be a minimum fee of \$50 for any checks returned as Non-Sufficient Funds (NSF).

Patient balances that go unpaid for 60 or more days may be referred to a collection company or attorney. In the event this occurs, you will be liable for the collection cost of a minimum of \$x. Further, in the event any unpaid account balance is referred to an attorney for collection, you may also be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

I understand that and agree to be responsible for payment of all services rendered on my behalf or my dependents' behalf.

I understand that I will be liable for the collection cost of a minimum of \$50. Further, in the event any unpaid account balance is referred to an attorney for collection, I agree also to be responsible for all costs and reasonable attorney's fees incurred in connection therewith.

Patient name:

Signature of Patient or Guardian : \_\_\_\_\_ Date : \_\_\_\_\_

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## X-ray Policy: \_\_\_\_\_

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I understand that x-rays are required for a complete and accurate exam. It is my responsibility to have any x-rays from my previous office sent to Dr. Stephanie Hirt DMD at Hirtmd3@gmail.com. If I fail to have these x-rays provided a cost may be incurred for new x-rays.

Signature: \_\_\_\_\_

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## Patient Questions - Preview

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### Questionnaire Title

Health Questionnaire

Are you under a physicians care now?

Yes

No

Are you under a physicians care now?

Have you ever been hospitalized or had a major operation?

Yes

No

If yes, please explain:

Have you ever had a serious head or neck injury?

Yes

No

If yes, please explain:

Are you taking any medications, pills, or drugs?

Yes

No

If yes, please explain:

Do you take, or have you taken, Phen-Fen or Redux?

Yes

No

Have you ever taken Fosamax, Boniva, Actonel, or any other Medications containing bisphosphates?

Yes

No

Are you on a special diet?

Yes

No

Do you use tobacco?

Yes

No

Do you use controlled substances?

Yes

No

Do you need to pre-medicate with antibiotic prior to dental procedures?

Yes

No

If yes, please explain:

Are you...

Pregnant or trying to get pregnant?

Taking oral contraceptives?

Nursing?

N/A

Are you allergic to any of the following?

Aspirin

Penicillin

Codeine

Local Anesthetics

Acrylic

Metal

Latex

Sulfa drugs

Other

If yes, please explain:

	Do you have, or have you had, any of the following?
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	AIDS or HIV Positive
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	Alzheimers Disease
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	Anaphylaxis
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	Anemia
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	Angina
--	--------

	Arthritis or Gout
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	Artificial Heart Valve
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	Artificial Joint
--	------------------

	Asthma
--	--------

	Blood Disease
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	Blood Transfusion
--	-------------------

	Breathing Problem
--	-------------------

	Bruise Easily
--	---------------

	Cancer
--	--------

	Cell Disease
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	Chemotherapy
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<input type="checkbox"/>	Chest Pains
<input type="checkbox"/>	Cold Sores or Fever Blisters
<input type="checkbox"/>	Congenital Heart Disorder
<input type="checkbox"/>	Convulsions
<input type="checkbox"/>	Cortisone Medicine
<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	Drug Addiction
<input type="checkbox"/>	Easily Winded
<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	Epilepsy or Seizures
<input type="checkbox"/>	Excessive Bleeding
<input type="checkbox"/>	Excessive Thirst
<input type="checkbox"/>	Fainting Spells or Dizziness
<input type="checkbox"/>	Frequent Cough
<input type="checkbox"/>	Frequent Diarrhea
<input type="checkbox"/>	Frequent Headaches
<input type="checkbox"/>	Genital Herpes
<input type="checkbox"/>	Glaucoma
<input type="checkbox"/>	Hay Fever
<input type="checkbox"/>	Heart Attack or Failure
<input type="checkbox"/>	Heart Murmur
<input type="checkbox"/>	Heart Pacemaker
<input type="checkbox"/>	Heart Trouble or Disease
<input type="checkbox"/>	Hemophilia

<input type="checkbox"/>	Hepatitis A
<input type="checkbox"/>	Hepatitis B or C
<input type="checkbox"/>	Herpes
<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	Hives or Rash
<input type="checkbox"/>	Hypoglycemia
<input type="checkbox"/>	Irregular Heartbeat
<input type="checkbox"/>	Kidney Problems
<input type="checkbox"/>	Leukemia
<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Low Blood Pressure
<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	Mitral Valve Prolapse
<input type="checkbox"/>	Osteoporosis
<input type="checkbox"/>	Pain in Jaw Joints
<input type="checkbox"/>	Parathyroid Disease
<input type="checkbox"/>	Psychiatric Care
<input type="checkbox"/>	Radiation Treatments
<input type="checkbox"/>	Recent Weight Loss
<input type="checkbox"/>	Renal Dialysis
<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	Rheumatism
<input type="checkbox"/>	Scarlet Fever

<input type="checkbox"/>	Shingles
<input type="checkbox"/>	Sickle Cell Disease
<input type="checkbox"/>	Sinus Trouble
<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	Stomach or Intestinal Disease
<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Swelling of Limbs
<input type="checkbox"/>	Thyroid Disease
<input type="checkbox"/>	Tonsillitis
<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	Tumors or Growths
<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	Yellow Jaundice
<input type="checkbox"/>	NONE OF THE ABOVE

<input type="checkbox"/>	Have you ever had any serious illness not listed above?
<input type="radio"/>	Yes
<input type="radio"/>	No
	If yes, please explain:

<input type="checkbox"/>	To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my
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<input type="checkbox"/>	Signature of patient, parent, or guardian:
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## **Cancellation Policy: \_\_\_\_\_**

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We understand there are times when you need to miss an appointment due to an emergency, and or other obligations. However, when you do not call or text our office to cancel an appointment, you may prevent another patient from getting needed treatment. On the contrary, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "FULL" schedule.

**If an appointment is not cancelled within 48 business hours, a \$50 fee will be placed on to your account.**

**\*\*\*\*\*THIS FEE WILL NOT BE COVERED BY YOUR INSURANCE COMPANY\*\*\*\*\***

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## Facts you need to know:

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**ESTHETIC CONSIDERATIONS:** It is our intent to use our technical and artistic capabilities to achieve your esthetic expectations and to incorporate these factors into your final dental restorations. You are asked to communicate your desires, and our best efforts will be applied toward incorporating your wishes in harmony with the functional and physiological requirements of the restorations.

**POTENTIAL PROBLEMS WITH FIXED PROSTHODONTICS:** Crowns and fixed bridges are used to treat problems of decay, severely worn or fractured teeth, malocclusion, and to protect teeth that have had root canal treatment. However, because dental restorations are replacements for natural teeth, potential problems do exist.

**IMPLANTS:** Longevity depends on many factors-the patient's health, the use of tobacco, alcohol, drugs, sugar, oral hygiene, the amount of quality bone, surgical compromises, the degree of biting force, etc. As with any restorative procedure, the potential exists for the fracture of an implant component, Implant crown, or loss of the implant from the bone.

**PROVISIONAL(Temporary) RESTORATIONS:** Provisional crowns and bridges are used to protect teeth and to provide a satisfactory appearance while the new permanent crown(s) and bridge(s) are being fabricated. A provisional restoration is usually made of a resin, which is not as strong as the final porcelain/metal restoration. A provisional is attached to the teeth with the temporary cement; therefore, it is important to minimize the chewing pressure on a provisional restoration since it can fracture and/or become dislodged. If this does occur, call our office as soon as possible for a repair or recementation. Waiting more than a few days can create unnecessary problems, and may delay your treatment.

**PORCELAIN FRACTURES:** Porcelain is the most suitable material for the esthetic replacement of the tooth enamel. Because porcelain is a "glass-like" substance, it can break. However, the strength of dental porcelain is similar to dental enamel, and the force necessary to fracture dental porcelain would usually fracture natural tooth enamel. Large porcelain fractures often require a new crown or fixed bridge.

**STAINS AND COLORS CHANGES:** All dental restorative materials can stain. The amount of stain generally depends on oral hygiene as well as the consumption of coffee, tea, tobacco, and some types of foods or medicines. Dental porcelain usually stains less than natural tooth enamel, and the most stain can be removed at dental hygiene cleaning appointments. Natural teeth tend to darken with time(more than porcelain crowns). At the time a new dental porcelain crown or fixed bridge is placed, it may be an excellent color match with the adjacent natural teeth. Over time, however, this may change.

**BLEACHING:** Bleaching provides a conservative method of lightening teeth. There is no way to predict to what extent a tooth will lighten. In a few instances, teeth may be resistant to the bleaching process, and other treatment alternatives may be advised. Infrequently, side effects such as tooth hypersensitivity and gum tissue irritation may be experienced. If these symptoms occur, technique modifications or products can usually alleviate the problem(s).

**TOOTH DECAY:** Some individuals are more prone to tooth decay than others. with a highly refined carbohydrate diet, Inadequate home care, smoking/vaping and dry mouth may all facilitate tooth decay.

-If the decay is discovered at an early stage, it can often be filled without remarking the crown or fixed bridge. Long delays in treatment, a loose provisional, or permanent crowns and bridges can result in additional decay, the "death" of a tooth nerve, which would require a root canal or even the loss of a tooth and/or teeth.

**LOOSE CROWN or LOOSE FIXED BRIDGE:** A dental crown or or fixed bridge may separate from the tooth if the cement is lost or if the tooth fractures beneath it. Most loosed crowns and fixed bridges can be recemented, but the teeth that have extensive recurrent decay or fractures will usually require a new crown, nex fixed bridge or extraction of the tooth in some cases.

**EXCESSIVE WEAR:** Sometimes crowns and fixed bridges are used to restore badly worn teeth. If the natural teeth were worn from cleanching and grinding the teeth(brusxism), the new crowns and fixed bridges may be subjected to the same wear. In many cases the "wear" is due to a parafunctional habit (such as clenching/grinding) and may require an "occulsal guard" to prevent further damage/breakdown.

**ADDITIONAL INFORMATION:** Sometimes when teeth are prepared for fillings or crowns due to the ectent of wear, deep decay, large fillings or old crowns, the additional "trauma" to an already compromised tooth can possibly cause the nerve of the tooth to die. This usually requires a referral to an endodontist ( a specialist who does root ranal treatment).

**MAINTENANCE:** Even the most beautiful restorations can be compromised by gum probelms, recurring cavities and poor oral hygiene habits. Part of our commitment to you is to provide you the proper information to keep your gums and teeth (natural or restored) in good health. Professional cleaning by a dental hygienist at the recommended intervals keeps your mouth healthy and can intercept potential problems earlt enough to avoid additional restorative work or unnecessary discomfort. It is also imporant to maintain a professional cleaning schedule throughout the course of your dental treatment.

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## Dental benefit/Insurance explanation:

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Dental benefits are often represented as being comparable to other types of insurance. **"Insurance", by definition, is protection against unpredictable or catastrophic loss.** Most dental benefit plans specifically *exclude* extraordinary needs. Offered dental benefits are not only predictable, but expected, such as routine exams, x-rays, healthy cleanings, etc. Further, policies that do offer a benefit for other common services, such as crowns and treatment for gum disease, provide them at a much lower percentage of the actual cost of providing that care.

Your dental benefit plan is an excellent maintenance assistance program that will help you protect your investment in your dental health.

A common misrepresentation is that dental "insurance" covers all the things you need done. We believe this can be a danger to your health, because it implies that *if it isn't covered, you don't need it.* You cannot count on a dental benefit plan to determine what you need; that is your responsibility. However, it's our responsibility to advise you regarding your health. Unless you have excellent dental health, your needs will require that you make an investment. We invest in what we value. We will work with your benefit plan to see you receive the maximum benefits in assisting you with the maintenance of your health. **We will work with you and are open to any questions you may have about your dental benefit.**

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