Stinauer family dentistry

Dr. John Stinauer
148 N. 5th Ave.
Canton, IL 61520
(309) 226-4717

Dr. Jesse Stinauer
2000 N. Main St.
Lewistown IL 61542
(309) 547-2200

Personal Information

Today's Date: ____________

Patient's name: ____________

____

Preferred Name: ____________

☐ *male* ☐ *female* *age:* ____________

Status: ☐*minor* ☐*single* ☐*married*

Date of birth ____________

Social Security # ____________

Driver's License # ____________

Home Address: ____________

____

____

Billing Address: ____________

(if different) ____________

Email Address: ____________

Please check preferred number to contact:

☐ *Home #* ____________

☐ *Work #* ____________

☐ *Cell #* ____________

Preferred method of appointment confirmation:

☐ *Text* ☐ *Phone call*

Employer: ____________

Occupation: ____________

Spouse's name: ____________

Do you have children? ☐ *Yes* ☐ *No*

How many? ____________

Do you have dental insurance?

☐ *Yes* ☐ *No*

Do we have a copy of your insurance card?

☐ *Yes* ☐ *No*

Person ultimately responsibly for account: ____________

Name: ____________

Relation: ____________

Referred to us by: ____________

Insurance Information

Primary insured's name: ____________

____

Relationship to patient: ____________

Primary employer: ____________

Primary's date of birth: ____________

Primary's social security #: ____________

Primary's address: ____________

____

____

Do you have secondary dental insurance? ☐ *Yes* ☐ *No*

Secondary insured's name: ____________

____

Relationship to patient: ____________

Secondary's employer: ____________

Secondary's date of birth: ____________

Secondary social security #: ____________

Secondary's address: ____________

____

____

Do you have any other supplemental insurance? ☐ *Yes* ☐ *No*

In event of emergency

Emergency contact name: ____________

____

Relationship to patient: ____________

____

Preferred number to contact: ____________

____

Who is your medical doctor: ____________

____

Medical doctor's phone #: ____________

____

Dental Information

Do you require antibiotic premedication before dental treatment? ☐ *Yes* ☐ *No*

If yes, why? ____________

Reason for today's visit?

☐ *Exam* ☐ *Emergency*

☐ *Consultation*

Are you in pain? ☐ *Yes* ☐ *No*

How long? ____________

Previous Dentist: ____________

Approximate date of last dental visit?

____

Please indicate any of the following problems:

☐ *Lost/Broken filling*

☐ *Dissatisfied with appearance of teeth*

☐ *Broken/chipped tooth*

☐ *Snoring*

☐ *Sleep apnea*

☐ *Clench/Grind teeth*

☐ *Clicking/Discomfort in jaw*

☐ *Sensitive teeth/gums*

☐ *Stained teeth*

☐ *Bad breath*

☐ *Missing teeth/Difficulty chewing*

☐ *Other*

Is there anything you would like to inform the doctor about past/future dental treatment? ____________

____

____

Medical Health History

Do you have, or have you had, any of the following?

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NAME: ______________________________

DATE: ______________________________

Heart Problems	yes	no
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood problems		
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion	☐	☐
Allergy problems		
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems		
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint problems		
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement *(e.g. total hip, pins, implants)*	☐	☐
Date of joint replacement: ____________		
Fainting spells, Seizures, or Epilepsy	☐	☐
Strokes	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Cancer/Tumor	☐	☐
Diabetes	☐	☐
If yes, please circle which type:	Type I/Type II	
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ____________		
Do you chew tobacco?	☐	☐

	yes	no
Do you smoke?	☐	☐
If so, how much? ____________		
Hepatitis, jaundice or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
History of head injury?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously that you feel we should know about?	☐	☐
If so, please describe: ____________		

LIST OF CURRENT MEDICATIONS: ______________________________

____

____

____

____

	yes	no
Have you ever been treated for osteoporosis with oral/IV medications? (bisphosphonates)	☐	☐
If yes, which kind and for how long? ____________		
During the past 12 months, have you taken any of the following?		
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g. Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drugs/supplements	☐	☐
Other ____________		
Are you allergic, or have you reacted adversely, to any of the following?		
Local anesthetics (novocaine)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, aceteminophen, or Ibuprofen	☐	☐
Codeine, demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex	☐	☐
Nuts	☐	☐
Other ____________		
Women		
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: ____________		
Are you nursing?	☐	☐

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We invite you to discuss with us any questions regarding our services.
The best dental health services are based on mutual respect between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collections agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature:______________________ Date:___/___/____

Acknowledgment of Receipt of Notice of Privacy Policies

I, ____, have seen a copy of this office's privacy policies.

Print name ____

Address ____

City ____

List family members who are also patients: ______________________________

____

____

List person(s) you authorize to receive information regarding treatment and billing: ______________

____

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Notice of Privacy Practices

Our promise:

This is not meant to alarm you, quite the opposite. It is our desire to communicate to you that the new Federal (HIPAA-Health Insurance Portability Accountability Act) laws, written to protect the confidentiality of your health information, are something we take seriously. We do not ever want you to delay treatment because you are afraid your personal health history might be unnecessarily released to others outside our office.

So what has changed? Why a Privacy Policy now?

The most significant variable that has motivated the federal government to legally enforce the importance of the privacy of health information is the rapid evolution of computer technology and its use in healthcare. The government has appropriately sought to standardize and protect the privacy of the electronic exchange of your health information. This has challenged us to review not only how your health information is used within our computers, but also how it's used with the internet, telephone, faxes, copy machines, and charts. We believe this has been an important exercise for us because it has disciplined us to put in writing the policies and procedures we use to ensure the protection of your health information everywhere that it is used.

We want you to know about these policies and procedures, which we developed to make sure your health information will not be shared with anyone that does not require it. Our office is subject to State and Federal law regarding the confidentiality of your health information and in keeping with these laws, we want you to understand our procedures and your rights as our valuable patient.

We will use and communicate your health information only for purposes of providing your treatment, obtaining payment, and conducting healthcare operations. Your health information will not be used for other purposes unless we have asked for, and been voluntarily given, permission.

How your health information may be used:

To provide treatment:

We will use your health information within our office to provide you with the best dental care possible. This may include administrative and clinical procedures designed to optimize scheduling and coordination of care between hygienist, dental assistant, dentist, and business staff. In addition, we may share your health information with physicians, referring dentists, clinical and dental laboratories, pharmacies, or other health care personnel providing you treatment.

To obtain payment:

We may include your health information with an invoice used to collect payment for treatment you receive in our office. We may do this with insurance forms filed for you in the mail or sent electronically. We will be sure to only work with companies with similar commitment to the security of your health information.

To conduct health care operations:

Your health information may be used during performance evaluations of our staff. Some of our best teaching opportunities use clinical situations experienced by patients receiving care in our office. Consequently, health information may be included in training programs for students, interns, associates, and business and clinical employees. It is also possible that health information will be disclosed to audits by insurance companies or government appointed agencies as part of their quality assurance and compliance reviews. Your health information may be reviewed during the routine process of certification, licensing, or credentialing activities.

Patient reminders:

Because we believe regular care is important to your oral and general health, we will remind you of a scheduled appointment or that it is time to contact us and make an appointment. Additionally, we may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

These communications are an important part of our philosophy of collaborating with our patients to be sure they receive the best preventative and restorative care modern dentistry can provide. They may include postcards, letters, telephone reminders, text messages, or emails, unless you tell us that you do not want these reminders.

Abuse or neglect:

We will notify government authorities if we believe a patient is the victim of abuse, neglect, or domestic violence. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specially required or authorized by law or with the patient's agreement.

Public health and national security:

We may be required to disclose to Federal officials or military authorities health information necessary to complete an investigation related to public heath or national security. Health information could be important when the government believes that the public safety could benefit when the information could lead to the control or prevention of an epidemic or the understanding of new side effects of a drug treatment or medical service.

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For law enforcement

As permitted or required by State or Federal law, we may disclose your health information to a law enforcement official for certain law enforcement purposes, including under certain limited circumstances, if your a victim of a crime, or in order to report a crime.

Family, friends, and caregivers

We may share your health information with those you tell us that will be helping you with your home hygiene, treatment, medications, or payment. We will be sure to ask your permission first. In the case of an emergency, where you are unable to tell us what you want we will use our very best judgment when sharing your health information only when it will be important to those participating in providing your care.

Authorization to use or disclose health information

Other than is stated above or where federal, state, or local law requires us, we will not disclose your health information other than with your authorization in writing at any time.

Patients' rights

This new law is careful to describe that you have the following rights related to your health information.

Restrictions

You have the right to request restrictions on certain uses and disclosures of your health information. Our office will make every effort to honor reasonable restriction preference from our patients.

Confidential communications

You have the right to request that we communicate with you in a certain way. You may request that we only communicate your health information privately with no other family members present or through mailed communications that are sealed. We will make every effort to honor your reasonable requests for confidential communications.

Inspect and copy your health information

You have the right to read, review, and copy your health information, including your complete chart, x-rays, and billing records. If you would like a copy of your health information, please let us know. We may need to charge you a reasonable fee to duplicate and assemble your copy.

Amend your health information

You have the right to ask us to update or modify your records if you believe your health information records are incorrect or incomplete. We will be happy to accommodate you as long as our office maintains this information. In order to standardize our process, please provide us with your request in writing and describe your reason for the change.

Your request may be denied if the health information record in question was not created by our office, is not part of our records, or if the records containing your health information are determined to be accurate and complete.

Documentation of health information

You have the right to ask for a description of how and where your health information was used by our office for any reason other than treatment, payment, or health operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward. Please let us know in writing the period for which you are interested. Thank you for limiting your request to no more than 6 years at a time. We may need to charge you a reasonable fee for your request.

Request a paper copy of this notice

You have the right to obtain a copy of this Notice of Privacy Practices directly from our office at any time. Stop by or give us a call and we will mail or email you a copy.

We are required by law to maintain the privacy of your health information and to provide you and your representatives this Notice of our Privacy Practices. While we are required to practice the policies and procedures described in this notice, we do reserve the right to change the terms of our notice. If we change our privacy practices, we will be sure all of our patients receive a copy of the revised notice.

You have the right to express complaints to us or to the Secretary of Health and Human Services if you believe privacy rights have been compromised. We encourage you to express any concerns you may have regarding the privacy of your information. Please let us know your concern or complaints in writing.