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

Cell Phone _____

Preferred Contact Method

Email Address _____

Emergency Contact Name: _____

Emergency Contact Phone: _____

Relation to Patient: _____

Employer Information

Employer:

How long with current employer:

Occupation: Data Analytics

Address 1:

State:

Zip:

Address 2:

City:

Other Information

Referred By:

Primary Physician:

How did you find us?:

Drivers License:

Consent to Treat Form: _____

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 a nd 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 attorne y 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 connecti on therewith.

Patient name:

Signature of Patient or Guardian : _____ Date :_____

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X-ray Policy:_____

I understand that x-rays are required for a complete and accurate exam. It is my responsibity to have any x-rays from my previous office sent to Dr. Stephanie Hirt DMD at Hirtdmd3@gmail.com. If I fail to have these x-rays provided a cost may be incured for new x-rays.

Signature: _____

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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?

- [ ] AIDS or HIV Positive
- [ ] Alzheimers Disease
- [ ] Anaphylaxis
- [ ] Anemia
- [ ] Angina
- [ ] Arthritis or Gout
- [ ] Artificial Heart Valve
- [ ] Artificial Joint
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breathing Problem
- [ ] Bruise Easily
- [ ] Cancer
- [ ] Cell Disease
- [ ] Chemotherapy

- [ ] Chest Pains
- [ ] Cold Sores or Fever Blisters
- [ ] Congenital Heart Disorder
- [ ] Convulsions
- [ ] Cortisone Medicine
- [ ] Diabetes
- [ ] Drug Addiction
- [ ] Easily Winded
- [ ] Emphysema
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Excessive Thirst
- [ ] Fainting Spells or Dizziness
- [ ] Frequent Cough
- [ ] Frequent Diarrhea
- [ ] Frequent Headaches
- [ ] Genital Herpes
- [ ] Glaucoma
- [ ] Hay Fever
- [ ] Heart Attack or Failure
- [ ] Heart Murmur
- [ ] Heart Pacemaker
- [ ] Heart Trouble or Disease
- [ ] Hemophilia

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

- [ ] Shingles
- [ ] Sickle Cell Disease
- [ ] Sinus Trouble
- [ ] Spina Bifida
- [ ] Stomach or Intestinal Disease
- [ ] Stroke
- [ ] Swelling of Limbs
- [ ] Thyroid Disease
- [ ] Tonsillitis
- [ ] Tuberculosis
- [ ] Tumors or Growths
- [ ] Ulcers
- [ ] Venereal Disease
- [ ] Yellow Jaundice
- [ ] NONE OF THE ABOVE

Have you ever had any serious illness not listed above?

- ( ) Yes
- ( ) No

If yes, please explain:

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

Signature of patient, parent, or guardian:

Cancellation Policy: _____

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 fom 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*******

Signature: _____

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Facts you need to know:

ESTHECTIC CONSIDERATIONS: It is our intent to use our technical and artistic capabilities to acheive 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 physlologocal requirements of the restorations.

POTENTIAL PROBLEMS WITH FIXED PROSTHODONTICS: Crowns and fixed bridges are used to treat problems of decay, severlely worn or fractured teeth, malocclusion, and to protect teeth that have had root canal treatment. However, because dental restortaions 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 facture of an implant component, Implant crown, or less 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 stain 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 endodonist (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 enought 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:

Dental benefits are oftern represented as being comparable to ther 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 predicable, bur 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 treatent 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 assisatnce 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 recieve 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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