Stuart Curry Dentistry
General & Cosmetic Dentistry

4851 Cahaba River Road, Suite 101
Birmingham, AL 35243
(205) 972-3831

Patient Information

Patient Name:

(last)_____(first)_____ (middle)_____ (preferred name)_____ Date:_____

☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Who may we thank for referring you? _____

Social Security #:_____ Birth Date:_____

Phone (home):_____ (work):_____ (ext):_____ Best time to call:_____

Phone (cell):_____ E-mail Address:_____

Address: (street):_____ (apartment #):_____

(city):_____ (state):_____ (zip code):_____

Health Information:

Date of last dental visit:_____ Reason for Visit:_____

Have you had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies_____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Pregnancy Due Date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ OTHER: _____ _____

Have you ever had any complications following dental treatment? ☐ Yes ☐ No

If yes, please explain:_____

Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No

If yes, please explain:_____

Are you now under the care of a physician? ☐ Yes ☐ No

If yes, please explain:_____

Name of Physician:_____ Phone #:_____

Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign this Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Signature

Spouse or Responsible Party Information, If other than Patient

Patient Name:

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name:

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other

Social Security #_____ Birth Date:_____

Phone (home): _____ (work):_____ ext:_____ Best time to Call:_____

Address: (street):_____ (city):_____ (st):_____ (zip code):_____

Employment Information:

The following is for ☐ the patient ☐ the person responsible for payment

Employer Name:_____ Occupation:_____

Address:_____ (city):_____ (st):_____ (zip code):_____

Insurance Information:

Primary

Name of Insured: (last):_____ (first):_____ (middle):

Is Insured a patient? ☐ Yes ☐ No (Insured's Birth Date):_____ (ID#):_____ (Group#):_____

Insured's Address: (street):_____ (city):_____ (st):_____ (zip):_____

Insured's Employer Name: _____

Employer Address: (street):_____ (city):_____ (st):_____ (zip):_____

Patient's relationship to Insured: ☐ (self) ☐ (spouse) ☐ (child) ☐ (other) _____

Insurance Plan Name _____

Address: (street):_____ (city):_____ (st):_____ (zip):_____

Secondary

Name of Insured: (last):_____ (first):_____ (middle):

Is Insured a patient? ☐ Yes ☐ No (Insured's Birth Date):_____ (ID#):_____ (Group#):_____

Insured's Address: (street):_____ (city):_____ (st):_____ (zip):_____

Insured's Employer Name: _____

Employer Address: (street):_____ (city):_____ (st):_____ (zip):_____

Patient's relationship to Insured: ☐ (self) ☐ (spouse) ☐ (child) ☐ (other) _____

Insurance Plan Name _____

Address: (street):_____ (city):_____ (st):_____ (zip):_____

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

I agree to pay any and all costs of collection should account become delinquent. I agree to pay any costs of collection, including a reasonable attorney's fee and hereby waive all rights of exemption under th laws of the State of Alabama.

I consent to the dentist's use and disclosure of my records (or my child's records) to carry out treatment, to obtain payment, and for those activities and health care operations that are related to treatment or payment.

I consent to the disclosure of my records (or my child's records) to the following persons who are involved in my care (or my child's care) or payment for that care.

I consent to pay a fee of $50 for broken or missed appointments without a 24 hour notice. After two broken or missed appointments, the Dentist retains the right to discontinue elective treatment.

I authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services, and I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, by my dental care payor.

I have read the above conditions of treatment and payment and agree to their content.

(Signature of patient, parent or guardian)_____ (Date)_____ (Relationship to Patient)_____

(Signature of guarantor of payment/responsible party): _____ (Date)_____ (Relationship to Patient)_____