Stockton Family & Cosmetic Dentistry, P.A.
5219 Two Notch Rd
Columbia SC 29204

Ruges F. Stockton, D.D.S.

PATIENT INFORMATION FORM

NOTE: The information on these forms is necessary for our records. It is considered strictly confidential. Please complete all parts.

○MISS
○MRS
○MR _____
LAST FIRST MIDDLE

DATE OF BIRTH_____ MARITAL STATUS_____ SEX_____

SOCIAL SECURITY NUMBER: _____

ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

HOME PHONE__(_____)-_____ CELL PHONE__(_____)-_____

BUSINESS PHONE __(_____)-_____ EMAIL: _____

DRIVERS LICENSE_____ STATE _____

OCCUPATION_____ WORK ADDRESS_____

DO YOU HAVE A PRIMARY PHYSICIAN? ○YES ○NO

PRIMARY PHYSICIAN'S NAME _____

PRIMARY PHYSICAN'S NUMBER (_____)_____ PHYSICIAN'S FAX: (____)_____

WHAT DO YOU WANT US TO DO FOR YOU? _____

WHO RECOMMENDED YOU TO OUR OFFICE? _____

EMERGENCY CONTACT INFORMATION (PERSON/RELATIVE NOT LIVING WITH YOU)

NAME_____ PHONE NUMBER _____

RELATIONSHIP TO PATIENT _____

ADDRESS _____
STREET APT# CITY STATE ZIP CODE

Phone: (803) 735-9446 | Fax: (803) 735-9813 | Email: stocktondentistry@hotmail.com

Stockton Family & Cosmetic Dentistry, P.A.
5219 Two Notch Rd
Columbia SC 29204

Ruges F. Stockton, D.D.S.

PATIENT'S NAME: _____ PATIENT'S DATE OF BIRTH: _____

RESPONSIBLE PARTY'S NAME _____
LAST FIRST MIDDLE

ADDRESS _____
STREET APT # CITY STATE ZIP CODE

DATE OF BIRTH _____ SSN_____ SEX _____

RELATIONSHIP TO PATIENT _____ MARTIAL STATUS _____

HOME PHONE _(_____)_____ CELL PHONE _(_____)_____

OCCUPATION _____ WORK PHONE (_____)_____

PRIMARY INSURANCE INFORMATION

POLICY #: _____ GROUP#/NAME: _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

SUBSCRIBER'S SSN OR ID#: _____

INSURANCE COMPANY NAME: _____ INSURANCE PHONE:_____

INSURANCE ADDRESS: _____

SECONDARY INSURANCE INFORMATION

POLICY #: _____ GROUP#/NAME: _____

SUBSCRIBER'S DATE OF BIRTH: _____ SUBSCRIBER'S NAME: _____

RELATIONSHIP TO PATIENT: _____

SUBSCRIBER'S ADDRESS: _____
STREET APT# CITY STATE ZIP CODE

SUBSCRIBER'S SSN OR ID#: _____

INSURANCE COMPANY NAME: _____ INSURANCE PHONE:_____

INSURANCE ADDRESS: _____

Phone: (803) 735-9446 | Fax: (803) 735-9813 | Email: stocktondentistry@hotmail.com

Stockton Family & Cosmetic Dentistry, P.A.
5219 Two Notch Rd
Columbia SC 29204

Ruges F. Stockton, D.D.S.

PATIENT NAME: _____ DATE OF BIRTH: _____

PERMIT FOR TREATMENT:

- This is to certify that I the undersigned consent to the performing of the dental and oral surgical procedures agreed to be necessary or advisable including the use of local anesthetic as indicated and will assume responsibility for fees associated with those procedures.

Patient/Legal Guardian Signature: _____ Date: _____

- I hereby authorize payment directly to Stockton Family &Cosmetic Dentistry, of the group insurance benefits otherwise payable to me.

Signed by Insured Person: _____ Date: _____

- I hereby authorize the release of information relative to this claim to the S.C. Department of Social Services and their assigns.

Patient/Legal Guardian Signature: _____ Date: _____

- I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). I have informed the Dentist of any known allergies. Certain medications may cause drowsiness and it is advisable not to drive or operate hazardous equipment when using such drugs.

Patient/Legal Guardian Signature: _____ Date: _____

- I hereby authorize Stockton Family & Cosmetic Dentistry to examine my teeth, mouth and neck, clean my teeth and apply fluoride, and to take the necessary radiographs (x-rays) of the teeth and jaws for diagnosis of my dental condition. The most common complications associated with dental treatment include nausea following the application of topical fluoride if it is swallowed. For patients with heart disease the risk of subacute bacterial endocarditis (heart infection) following dental treatment exists; therefore antibiotics will be prescribed before the treatment to minimize the risk. Exposure to x-rays can be damaging to an unborn child. Pregnant women should notify if they are pregnant.

Patient/Legal Guardian Signature: _____ Date: _____

Phone: (803) 735-9446 | Fax: (803) 735-9813 | Email: stocktondentistry@hotmail.com

Stockton Family & Cosmetic Dentistry, P.A.
5219 Two Notch Rd
Columbia SC 29204

Ruges F. Stockton, D.D.S.

PATIENT NAME: _____ DATE OF BIRTH: _____

- I understand that during treatment it may be necessary to change and/or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Patient/Legal Guardian Signature: _____ Date: _____

- I understand that oftentimes patients are shown "before and after" photographs of procedures that were completed at Stockton Family Dentistry via intraoral/extra oral technology. I understand that photographs may be used for in-office use and other educational purposes. I understand that my face will not be present in these photographs unless I sign a written release form.

Patient/Legal Guardian Signature: _____ Date: _____

- I hereby give permission for Stockton Family Dentistry to contact me via email concerning appointment dates/times as deemed necessary for confirmation and contact purposes. I understand that my email address is strictly confidential and will not be given out to third parties.

Patient/Legal Guardian Signature: _____ Date: _____

- I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction. I also understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I make known that I choose to terminate it.

Patient/Legal Guardian Signature: _____ Date: _____

Phone: (803) 735-9446 | Fax: (803) 735-9813 | Email: stocktondentistry@hotmail.com