Welcome

Date: _____

Patient's Name: _____SSN: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____ Sex: (Male) _____ (Female) _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Status: Single _____ Married _____ Divorced _____ Widow _____ Life Partner _____ Spouse Name: _____

Employer: _____ Occupation: _____ Email: _____

How did you hear about us? _____

In Case of an emergency, who should we notify? _____

Relationship: _____ Phone# _____

The purpose of your visit today? _____

Person(s) responsible for this account

Name: _____ Relationship to patient: _____

Do you have Insurance? (Yes) ___ (No) ___ if Yes, Name of insurance company: _____

Policy Holders: If you have **Federal** Blue Cross/ Blue Shield, it is considered as your primary insurance.

Name of the Policy Holder: _____ Date of Birth: _____

SSN: _____ Work Phone: _____

Employer: _____ Occupation: _____

Do you have secondary insurance? **(Yes) ___ (No) ___ if Yes, Name of insurance company: _____**

Name of the Policy Holder: _____ Date of Birth: _____

SSN: _____ Work Phone: _____

Employer: _____ Occupation: _____

Terms and Conditions

Whether you have dental insurance or not, you have final responsibility for our treatment fees being paid.
we also have extended financing plans available for qualified patients who need or want extensive treatment. In the event of a broken appointment with less than **24 hours notice,** a fee of **$50.00** will be applied to your account. In the event that this account becomes past due, the doctors, their assigns, or lawful agents may consider the account in default and pursue collections procedures. If any account is past due, I agree to pay 1.5% interest per month (18% annum) on the unpaid balance from the due date, in addition to collection cost. Collection cost may include, but are not limited to, court filing fees, service or processing costs, and reasonable attorney fees of 30% of unpaid principal. Any returned check will be charged fee of **$35.00.**

Signature of Patient, Parent, or Guardian: _____

Medical Information

Although dental personnel primarily treat the area of the mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	_____
Have you ever been hospitalized or had a major operation?	Yes	No	_____
Have you ever had a serious head or neck injury?	Yes	No	_____
Are you taking any medications, pills, or drugs?	Yes	No	_____
Do you use tobacco?	Yes	No	
Do you use a controlled substance?	Yes	No	

Females: Are you Pregnant/ trying to get pregnant? Yes No
Are you nursing? Yes No Taking Oral Contraceptives? Yes No

Are you Allergic to any of the following? **(Please circle)**
Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other _____

Health Information

***PLEASE CHECK THOSE THAT APPLY**

□AIDS/HIV +	□Chest Pains	□Genital Herpes	□Kidney Problems	□Shingles
□Alzheimer's Disease	□Cold Sores/ Fever Blisters	□Glaucoma	□Leukemia	□Sickle Cell
□Anaphylaxis	□Congenital Heart Disorder	□Hay fever	□Liver Disease	□Sinus Trouble
□Anemia	□Convulsions	□Heart Attack/ Failure	□Low Blood Pressure	□Spine Bifida
□Angina	□Cortisone Medicine	□Heart Murmur	□Lung Disease	□Stomach/ Intestinal Disease
□Arthritis/ Gout	□Diabetes	□Heart Pace Maker	□Mitral Valve Prolapse	□Stroke
□Artificial Heart Valve	□Drug Addiction	□Heart Trouble/ Disease	□Pain in Jaw Joints	□Swelling of Limbs
□Artificial Joint	□Easily Winded	□Hemophilia	□Parathyroid Disease	□Thyroid Disease
□Asthma	□Emphysema	□Hepatitis A	□Psychiatric Care	□Tonsillitis
□Blood Disease	□Epilepsy or Seizures	□Hepatitis B or C	□Radiation Treatments	□Tuberculosis
□Blood Transfusion	□Excessive Thirst	□Herpes	□Recent Weight Loss	□Tumors or Growths
□Breathing Problems	□Fainting Spells/ Dizziness	□High Blood Pressure	□Renal/ Kidney Disease	□Ulcers
□Bruise easily	□Frequent Cough	□Hives or Rash	□Rheumatic Fever	□Venereal Disease
□Cancer	□Frequent Diarrhea	□Hypoglycemia	□Rheumatism	□Yellow Jaundice
□Chemotherapy	□Frequent Headaches	□Irregular Heartbeat	□Scarlet Fever	

Have you ever had any serious illness not listed above? Yes No

Name and phone number and/or address of Primary Physician? : _____

List of Medications: _____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be detrimental to my (or Patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Reviewed by: _____

Office Policies

Our professional treatment is rendered to you, not the insurance company. You are responsible for payment of all treatment.
As a courtesy to you we will file your insurance claims for you as long as you can go to the **Dentist of your choice**.

Please understand that your insurance policy is a contract between you and your insurance company. Any problems with a non-payment, is your responsibility. Remember that dental benefits were never intended to dictate your dental care; they are to assist in payment of dental care.

Any insurance balance over 90 days old is delinquent and is your responsibility to pay.

Your dental benefits were determined by your employer and insurance company and not by this office. Most policies cover a percentage of what they call "Usual and Customary Fee". However the insurance companies establish these fees based on their needs and not yours. These fees are not always the same as the fees charged in this office.

We will do our best to see that you receive your full benefits. However, ultimate responsibility for payment is yours. Financial arrangements must be made before dental treatment begins.

Authorization and Release

I have read the above office policy, terms and conditions of treatment and payment and agree to their content.
I understand that I am financially responsible for all charges whether or not paid by insurance, I authorize the release of information necessary to process all dental claims and authorize payment to John G. Stephenson, D.M.D for professional services rendered.

Signature: _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices from the office of John G. Stephenson, D.M.D. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

John G. Stephenson, D.M.D. reserves the right to change the privacy practices that are describes in the statement of privacy practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family	□Yes	□No
Spouse only	□Yes	□No
Other (please specify) _____	□Yes	□No

Print Patient's Name: _____

Signature of Patient Parent, or Guardian: _____ Date: _____

OFFICE USE ONLY

Record of Acknowledgement given before treatment? Yes No

Reason for Denial: _____

Reviewed by: _____ Date Provided: _____