SCOTT J. STEPHENS, D.D.S.
FAMILY AND COSMETIC DENTISTRY

Patient Information

Please turn off cell phones while in Treatment rooms. Thank You.

Date: ________

Patient *Legal* Name: ____Preferred Name:________________
Last First MI

Address: ____
Street City/State Zip code

Sex: M F Marital Status: _________ Birth Date: ______________ Social Security #: _________________

Ph (Home): ________________ Ph (Work): _______________ Ext: _____ Cell ________________________

Employer/School____________________ Best time to call: _________ Email:____________________________

Nearest relative not living with you: (name)______________________________(phone#)___________________

Would you like appt reminders sent via email?__________

Insurance Information

(*if applicable or not previously provided*)

Subscriber Name _______________________SS#____________________ Birth Date ____________

Insurance Company ______________________ Phone ____________ Employer Name _________________

Responsible Party

(Person responsible for account if different than above)

Name________________ Relationship _________________ Ph (home)___________Ph (work)_____________

Address: ____
Street City/State/Zip Code

****Referral Information****

Yellow Pages ____ Newspaper ____ Drive-By ____ Delta Dental Website ____ BCBS Website____

Another patient, Name: _______________ A Dental Office, Name: _____________

ScottStephensdds.com________ Radio______ Family member___________

NAME Last:____________________ First:_____________________ MI:__________ Date:____________________

DOB:____________________ SEX: M / F

MEDICAL HISTORY

Do you have a personal physician? Y N
Are you currently under a physician's care? Y N
If so, why? ____
____
Physician's Name:____
Phone #: ____________________ Date of last visit: ______________

YOUR CURRENT PHYSICAL HEALTH IS:
Good Fair Poor

Do you smoke or use tobacco in any form? Y N
Do you have any implants, valves, rods or pins? Y N
Are you taking any medications? Y N
Please list:____
____
____
____

Have you been hospitalized, had a serious illness or surgery in the past three years?
If yes, why?____
____
____
____

Have you ever taken Phen-Fen/Redux/Pondimin?
If yes, when?____
Have you ever taken Fosamax?____
If yes, when?____

FOR WOMEN: Are you taking birth control pills? Y N
Are you pregnant? Y N Week #:______________________
Are you nursing? Y N

Have you ever had any of the following diseases or medical problems? (Please answer all that apply)

Y	N	Alcohol/Drug Abuse (Addiction)	Y	N	Hepatitis
Y	N	Anemia	Y	N	Herpes/Fever Blisters
Y	N	Arthritis	Y	N	High Blood Pressure
Y	N	Artificial Valves	Y	N	Artificial Joint
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Birth Defects	Y	N	Hospitalized for any reason
Y	N	Excessive Bleeding	Y	N	Kidney Disease
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Bruise Easily	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Organ Transplant
Y	N	Dentures/Partials	Y	N	Pace Maker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Therapy
Y	N	Dry Mouth	Y	N	Rheumatic Fever
Y	N	Eating Disorder	Y	N	Seizures
Y	N	Emphysema	Y	N	Shingles
Y	N	Epilepsy	Y	N	Sickle Cell Trait/Disease
Y	N	Fainting/Dizzy Spells	Y	N	STD
Y	N	Frequent Headache/Migraine	Y	N	Steroid Treatment
Y	N	Glaucoma	Y	N	Stroke
Y	N	Heart Attack	Y	N	Thyroid, adrenal disease
Y	N	Heart Murmur	Y	N	Tuberculosis
Y	N	Heart Surgery	Y	N	Ulcers
Y	N	Hemophilia			

Please list any other serious medical condition(s) that you have had which are not listed above:____
____
____
____

Are you **Allergic** to any of the following? Y N (Please circle all that apply)

Aspirin	Erythromycin	Metals
Barbituates	Iodine	Penicillin
Codeine	Jewelry	Sulfa Drugs
Dental Anesthetics	Latex	Tetracycline

Please list any other drugs/materials that you are allergic to:__________________

DENTAL HISTORY

What is the primary reason for your visit to our practice today?_______________
____
____

Are you currently in pain? Y N
Do you require antibiotics before dental treatment? Y N

YOUR CURRENT DENTAL HEALTH IS:
Good Fair Poor

When was the last time you had a complete dental evaluation?________________
____

Have you ever had a serious/difficult problem associated with previous dental work? Y N
Do you floss regularly? Y N Brush daily? Y N

Have you ever been informed or treated for the following dental conditions:

Y	N	Bleeding Gums	Y	N	Mobility of Teeth
Y	N	Bad Taste/Odor	Y	N	Oral Cancer/Biopsy
Y	N	Cold Sores/Ulcers	Y	N	Osseous Surgery
Y	N	Deep Cleanings/Scalings	Y	N	TMJ/TMD Joint Pain
Y	N	Gum/Periodontal Disease	Y	N	Toothbrush Abrasion
Y	N	Hot/Cold Sensitivity	Y	N	Wisdom Teeth Extraction

Would you like fresher breath? Y N
Would you be interested in whiter teeth? Y N
Are you happy with the way your smile looks? Y N
If not, what would you change?______________________________
____
____

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize treatment and the use of anesthesia, oral sedation and/or other medications necessary for dental treatment to be rendered by the dental staff.

____
Patient's (parent) Signature Date

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FINANCIAL POLICY

Please Initial Below:

_____ Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is meant only to assist you.

______ We accept all private insurance plans. We are network providers for Delta Dental, Blue Cross Blue Shield, and United Concordia. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most current information we have, but it is ONLY AN ESTIMATE.

______ We will bill your insurance as a courtesy. If your insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare, but is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

______ We require payment in full for the estimated co-payment at the time of service. We accept all major credit cards, cash, and checks (for existing patients with established payment history.) We also work with Care Credit, who offers a 12 month "interest free" option. A $25 charge may be incurred on returned checks. In the event that an account is turned over to an outside collection agency for collection, the patient is responsible for all collection/attorney fees incurred by Scott J. Stephens as a result of non-payment.

______ A specific amount of time is reserved especially for you, and we strongly encourage all patients to keep their appointment. We require at least a 48-hour notice to avoid a cancellation charge of $50.

______ I hereby authorize the release of any information, including the diagnosis and records of any treatments, x-rays, photographs, or examinations rendered, to my insurance company. I hereby authorize my insurance company to pay directly to Scott J. Stephens, D.D.S. and any proceeds payable under the terms of my insurance policy. I hereby authorize Scott J. Stephens to perform dental procedures on me, my minor children, and/or family members.

I agree with the above conditions.

Print Name: ____ Date:__________

Patient/Parent Signature: ____

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Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance officer in person or by phone at our Main Phone Number.

Your signature below is an acknowledgement that you have read and understand this Notice of our Privacy Practices. **If you would like a copy of your records, please make your request known with our front desk personnel.**

Patient/Parent Signature: ____ Date: ____________