PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only
Medical Alerts:

Sex:

If female please answer the following:

Y N
- ☐ ☐ Are you taking Birth Control Pills?
- ☐ ☐ Are you pregnant? If Yes, # of weeks ☐
- ☐ ☐ Are you nursing?

Please answer the following:

Y N
- ☐ ☐ Do you smoke or use tobacco?

For Office Use Only
BP ☐ Heart Rate: ☐

Height: ☐
Weight: ☐

Y	N	Conditions
☐	☐	Abnormal Bleeding
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Artificial Joints
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer- Chemotherapy
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Epilepsy
☐	☐	Fever Blisters
☐	☐	HIV+ AIDS
☐	☐	Heart Attack
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hemophilia
☐	☐	Hepatitis
☐	☐	High Blood Pressure
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse

Y	N	Conditions
☐	☐	Pace Maker
☐	☐	Pain In Jaw Joints
☐	☐	Rheumatic Fever
☐	☐	Stroke
☐	☐	Tuberculosis
☐	☐	Artificial Heart Valve
☐	☐	Alzheimer's Disease
☐	☐	
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Y	N	Conditions
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	
☐	☐	

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

Dental Patient Policies Form

Thank you for choosing Stephens General Dentistry for your dental care. Our primary goal is to provide thorough dental care in a comfortable relaxed environment. To ensure a long-lasting and well-informed relationship we have listed our policies as they concern you. Please read through the following policy information and sign where indicated. Should you have any questions, please do not hesitate to ask one of our team members. Thank you.

Financial Policy

Insurance- If you have dental insurance, we will complete your insurance form and submit it to your insurance company as a courtesy. Although our office will call your Insurance provider for an explanation of benefits, PLEASE UNDERSTAND THAT IT IS YOUR RESPONSIBILITY TO CONFRM AND MAINTAIN CURRENT COVERAGE WITH YOUR INSURANCE PROVIDER. OUR OFFICE DOES NOT GUARANTEE PAYMENT OR COVERAGE BY YOUR INSURANCE POLICY. IN THE EVENT THAT YOUR PROVIDER DOES NOT COVER A PROCEDURE, YOU THE PATIENT BECOME FULLY FINANCIALLY RESPONSIBLE FOR TREATMENT COMPLETED.

Payments- Upon completion of your dental appointment, the front desk team will produce an invoice outlining the costs. You will be expected to pay for services provided AT THAT APPOINTMENT. In the event your account becomes delinquent, Stephens General Dentistry reserves the right to provide your data to our designated collection company. Your signature marks your agreement to allowing Stephens General Dentistry to transfer your information to the designated collection company if this situation arises. All past due balances after 90 days will accrue a set interest rate of 10% each month of the account balance; you further agree to a one time collection fee of $50 that will be added to your account by Stephens General Dentistry once a collection agent becomes involved.

Forms of payment- Cash, Check, Visa, MasterCard, Discover, American Express, and Care Credit.

NSF Checks- If we receive a check returned to us for insufficient funds, the following would occur: 1) A $35.00 charge will be applied to your account. 2) You must clear the account promptly by cash, certified check, money order, or credit/debit card. 3) Your privilege to write checks may be jeopardized.

Scheduling Policy

Rescheduling or Canceling Appointments- The office requires that you inform us if you need to reschedule or cancel at least ONE working day prior to that appointment. We do not take cancellations on the answering machine. Missed multiple appointments may jeopardize future appointments.

Appointment Confirmation- We will make every attempt to reach you prior to your appointment. We ask that you please reply to us to let us know you will be making your scheduled appointment. If we have not received confirmation we reserve the right to give your treatment time to another patient.

Missed and Late Appointments- Your appointment time has been reserved especially for you at exclusion of others who may be waiting for an appointment. If you miss your appointment and we do not receive adequate prior notice, we will have no time to fill your time space. We therefore reserve the right to charge for missed appointments in the fee of $35.00. If you should arrive late, we may not be able to see you for that appointment.

I HAVE READ AND AGREE TO ALL POLICIES ABOVE

Printed Name_____

Signature_____Date_____

THIS INFORMATION DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Stephens General Dentistry is to serve our customers with professionalism and a caring atmosphere, being sure at all times to protect the privacy and security of all Protected Health Information.

During the course of serving your interests it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared.

*For payment purposes we may use the services of a billing agency.

*During dental treatment we may need a second opinion, or the need to refer to an endodontist, oral surgeon, periodontist, or an orthodontist.

*X-rays and treatment records may be sent to your insurance company for their payment of services rendered.

*Other dental offices or specialists may request your records and/or x-rays if they are treating you and they will be sent at your consent.

We here at Stephens General Dentistry are committed to obeying all Federal, State, and Local laws and regulations regarding Privacy Practices. If any other uses or disclosures that the ones listed above are needed, information will only be released with the written authorization of the individual in question. This written authorization may be revoked at any time by the individual, as provided by law.

If you have any questions or comments regarding your Protected Health Information, please feel free to contact our Compliance Officer, 918-683-2010.

I have read and understand the above Notice of Privacy Practices.

Signed_____Date_____