New Patient Form

Dr. Scott Stephens
Family & Cosmetic Dentistry

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Demographics

First Name: _____ Last Name:_____

Preferred Name: _____ □ Male □ Female □ Prefer not to say

Date of Birth: _____/_____/_____ SSN:_____

Address: _____

City: _____ State: _____ Zip:_____

Primary Phone: _____ E-mail:_____

Marital Status: □ Married □ Single □ Divorced □ Minor □ Other

Emergency Contact: _____ Phone: _____ Relationship: _____

Insurance

Do you have dental insurance? □ Yes □ No

Name of Policy Holder:_____ DOB: ____/____/_____ Relationship:_____

Dental Insurance Company: _____ Group #:_____ ID#:_____

Employer:_____

Dental History

Reason for Today's Visit: _____ Date of Last Dental Visit: ____/___/_____

Have you had serious problems with previous dental treatment? □ Yes □No

If you answered "Yes" to the previous question, please explain:

_____

_____

Do you have discomfort in your mouth? □ Yes □ No | If "Yes", where? _____

Do your gums bleed when you brush or floss? □ Yes □ No | Have you been told you grind your teeth? □ Yes □ No

How often do you brush daily? _____ Floss? _____

With 10 being the best, please rate your **smile**: 1 2 3 4 5 6 7 8 9 10 | **Color of your teeth**: 1 2 3 4 5 6 7 8 9 10

Assignment and Release:

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Dr. Scott Stephens Family & Cosmetic Dentistry all insurance benefits, if any, otherwise payable to me for service rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions. I understand that proper diagnosis can only come after an examination is done and radiographs are taken. I hereby authorize Dr. Stephens to perform any necessary examination and radiographs needed for a proper diagnosis.

Responsible Party Signature:_____ Date: ____/____/_____ Relationship: _____

Medical History

Condition	Yes	No	Condition	Yes	No
Anemia/Blood Disorder			Headaches/Migraines		
Artificial Joint			Hepatitis A, B, C, or D		
If yes, when?			High Blood Pressure		
Asthma			Implant		
AIDS/HIV Infection			If yes, when?		
Alcohol/Drug Dependency			Kidney Problems		
Congenital Heart Disease			Pacemaker		
Diabetes			Psychiatric Disorder		
Digestive Disorder			Seizures		
Dry Mouth			Stroke		
Epilepsy/Seizures			Tobacco Use		
Excessive Bleeding			Thyroid Disease		
Fainting/Blackouts			Tuberculosis/Lung Problems		
Heart Attack/Trouble			Tumors, Cancer, Radiation		
Heart Valve Disorder			Ulcers/Acid Reflux/Heartburn		
Heart Surgery					

Periodontal disease has been linked to the following conditions. Do you have family history of any of the conditions listed below?

☐ Heart Disease ☐ Stroke ☐ Diabetes ☐ Early-term Birth ☐ Cancer ☐ Dementia

Are you currently pregnant? ☐ Yes ☐ No | If yes, when are you expecting? _____

Have you seen a physician or been hospitalized in the last two years (including pregnancy)? ☐ Yes ☐ No

If yes, please explain:_____

Physician's Name:_____ Phone:_____ Specialty:_____

Medicine

Have you ever had an allergic reaction to any substance or medication? ☐ Yes ☐ No

If yes, please explain:_____

Has a physician recommended you pre-medicate prior to dental procedures? ☐ Yes ☐ No

If yes, please explain:_____

Please list any prescription or over the counter drugs, medications, or vitamins you are currently taking:

At Dr. Stephens Family & Cosmetic Dentistry, we offer a variety of services to enhance your comfort and keep your smile beautiful. Please choose any services below that you would like our staff to discuss with you during your visit.

☐ Veneers ☐ Implants ☐ Whitening ☐ Braces ☐ Partials/Dentures ☐ Nightguards/Sport Appliances

Financial Policy

Please read the information below. Initial and sign to indicate you understand your role in financing your dental treatment.

Your dental benefits are base upon a contract made between your employer and the insurance company. Please contact your employer or insurance company directly if you have questions regarding your dental benefits.

Please Initial Below:

_____ We require payment in full for treatment at the time of service. If using dental insurance benefits, your estimated portion will be due at the time of service. We accept all major credit cards, cash, and checks (existing patients with established payment history). We also work with the health care financing companies Care Credit and Lending Club who often offer 6-month interest free options. A $25 charge may be incurred for returned checks.

_____ In the event that your account is turned over to an outside collection agency for collection, you are responsible for collection fees as well as the balance due for services rendered. This may include any cancellation fees.

_____ We are in network with some dental insurance plans. We will, however, file most private, primary insurance claims as a courtesy even if we are not in network. If your insurance does not pay within 30 days, we may request payment in full. You would then work with the insurance to collect funds that are due to you.

_____ Dental insurance typically covers only a portion of your dental treatment. Your **estimated** portion is due at the time of service. It is only an **estimate** based on the limited information we have available. Insurance companies are not required to provide us with comprehensive information regarding your benefits.

_____ 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.

Cancellation/No Show Policy

_____ **Appointments must be confirmed by noon the business day prior to your appointment**. Failure to confirm your appointments may result in cancellation. There may be a $50 cancellation fee if multiple instances of cancellations or failure to keep your appointments occur. We understand that situations such as medical emergencies occasionally occur, and an appointment cannot be kept, or adequate notice is not possible. These situations will be considered on a case-by-case basis.

Patient Name Printed: _____

Signature: _____

Date: ____/____/_____ Relationship to Patient: _____

Acknowledgement and Receipt of Notice of Privacy Practices

Patient Name:_____ Date:___/___/_____

- ❖ I have been offered and/or received a copy of the currently effective Notice of Privacy Practices for Dr. Scott Stephens.
- ❖ I may refuse to sign.
- ❖ Expiration: 3 years from initial/last signature; insurance change; patient reaches age of 18.
- ❖ I understand that I may request a copy of the privacy policies at any time.
- ❖ I understand that my PHI (Protected Health Information) can and will be used for purposes of treatment and for payment from both myself and/or third party.
- ❖

Please list any other parties who may have access to your dental information

Name: _____ Relationship:_____ Phone:_____

Name: _____ Relationship:_____ Phone:_____

I authorize contact from this office to:

- ❖ Confirm my dental appointments
- ❖ Discuss treatment and billing information
- ❖ Relay information about my dental health

I would like to be contacted via:

□ Home Phone □ Cell Phone □ Work Phone □ E-mail □ U.S. Mail □ Any Method

_____ _____

Please ***print*** your name Please ***sign*** your name

If you would like a copy of this packet, please ask one of our Patient Care Coordinators. They would be happy to get you any information you need.