

PATRICK H. STEPHENS, D.M.D., P.C.
7 Carl Midway Church Road
Auburn, Georgia 30011 (770) 867-6144

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: _____

Preferred Name: _____

Patient Information

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

Email: _____ I would like to receive correspondence via email.

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc. Sec: _____ Drivers Lic: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Patient: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Insurance: _____ Employer: _____

Address: _____

City, State, Zip: _____

Dental History

Have you ever had any serious trouble associated with previous dental treatments? :

Have you ever been treated for periodontal disease (gum disease)?: _____

If so, when? _____

Do you have or have you ever had any of the following?

Mouth: Bleeding, sore gums..... Yes No

Unpleasant taste/bad breath..... Yes No

Swelling/Lumps in mouth..... Yes No

Ortho treatments (braces)..... Yes No

Teeth: Loose teeth..... Yes No

Sensitive to hot/cold..... Yes No

Sensitive to sweets..... Yes No

Sensitive to biting..... Yes No

Food Impaction..... Yes No

Patrick H. Stephens, D.M.D., P.C.

MEDICAL HISTORY

Name: _____ Birth Date: _____

Although dental personnel primarily treat the area in and around your 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 If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

Women: Are you _____

Pregnant/Trying to get pregnant? Nursing?

Taking oral contraceptives?

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain: _____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

Whom may we thank for referring you? _____

Signature of Patient _____ Date _____
(Parent or Guardian if Patient is a Minor)

Health History review for Doctor's Use Only _____ Date _____

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FINANCIAL ARRANGEMENTS – PLEASE READ CAREFULLY

Our mission is to deliver the finest, most cost effective dental care treatment available today. Following your diagnosis, the doctor will advise you of our plan for treatment. Additionally, we will discuss with you the cost of today's and future treatments.

Payment for today's visit and your future visits is due at the time of treatment. We are sensitive to the fact that some patients may not be able to pay cash for their treatment; therefore, we offer several alternative payment programs for your convenience.

1. **Cash/Check**
 2. **MasterCard/Visa/Discover**
 3. **CareCredit®** - We participate with CareCredit® financing, a revolving credit card that is accepted at other health care facilities. CareCredit® offers low monthly payments and low interest options for qualified applicants. We can assist you with the application in our office, or you may apply online at www.carecredit.com.
 4. **Insurance filing** – Our office will be happy to work with you and your insurance company to maximize your dental benefits; however, your insurance is between you and your employer. It is your responsibility as a patient to give your insurance information to the front office and to notify us with any changes in your policy for future visits. Any charges not paid for by your dental insurance such as deductible, non-covered services or your fee percentages are to be paid for at time of service unless pre-approved financial arrangements have been made with the front office. To assist us in filing your insurance claims, you must provide us with a schedule of benefits or an employee handbook if one has not been provided by your employer. We will be glad to check on your claims if not paid within a reasonable time; however we cannot hold billing for any length longer than 3 months from the date the treatment service was completed. Please realize, we file your insurance as a courtesy to you, our patient. In the event that your account becomes delinquent and is turned over to a collection agency, any fees charged by the collection agency will be your responsibility.
- **NOTE:** When extensive dental treatment is anticipated, a treatment plan will be discussed with you before treatment begins along with the expected cost of the treatment. If financial arrangements are needed, these are to be made prior to your visit and a financial agreement form must be completed and signed by the responsible party.

X _____ DATE: _____

Signature of patient or responsible party

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Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
 - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
 - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
 - The right to receive confidential communications of protected health information.
 - The right to inspect and copy protected health information.
 - The right to amend protected health information.
 - The right to receive an accounting of disclosures of protected health information.
 - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient): _____