Date: _____

Last Name:_____ First:_____ Middle:_____

What name would you like to use? _____ Sex (circle one): male female

Marital Status (circle one): Single Married Date of Birth: _____ Age: _____

Social Security #: _____

Address:_____City:_____ State:___ Zip:_____

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

Email:_____ May we contact you through email? _____

Best time to contact:_____

Employer:_____City:_____State:____ Zip:_____

Occupation _____

Name of Spouse: _____ Spouse's Phone Number: _____

RESPONSIBLE PARTY (if other than patient) **PARENT'S NAME (if child)**

Name:_____ Relation to patient:_____

Address:_____City:_____ State:_____ Zip:_____

Home Phone:_____ Cell Phone:_____ Work Phone_____

Emergency Contact (<u>OTHER THAN SPOUSE</u>):

Name: _____

Relationship_____ Phone Number:_____

What is your reason for today's visit? _____

Is any other member of your family a patient in our practice? _____

How did you learn about our practice? ☐ Website ☐ Yellow pages ☐ Facebook ☐ Family

☐ Friend if so, their name_____

Are you under any medical treatment now? (I.e. chemo/radiation) If yes, explain.

_____

Have you had any major operations? (I.e. Bypass, joint replacements) If yes, explain.

_____

Have you had a serious accident involving head or jaw injuries? If yes, explain.

_____

Are you taking any blood thinners?

_____

Are you pregnant or breastfeeding? If pregnant, how far along are you?

_____

<u>Please turn over to complete form</u>

Medical Conditions: Check YES OR NO

A.I.D.S/H.I.V. positive	____Yes ____No	Hearing Loss	____Yes ____No	Tumor or Growths	____Yes ____No
Bleeding Problems	____Yes ____No	Heart Ailment/Murmur	____Yes ____No	Venereal Disease	____Yes ____No
Blood Disease	____Yes ____No	High/Low Blood Pressure	____ Yes ____No	X-Ray Treatments	____ Yes ____No
Diabetes	____Yes ____No	Kidney Disease	____Yes ____No	Yellow Jaundice/Hepatitis	____Yes ____No
Do you smoke?	____Yes ____No	Liver Disease	____Yes ____No	Arthritis	____ Yes ____No
Dry Mouth	____Yes ____No	Respiratory Disease	____Yes ____No		
Epilepsy	____Yes ____No	Sleep Apnea	____Yes ____No		
Fainting	____ Yes ____No	Stomach/Intestinal Disease	____Yes ____No		

Please list any allergies (drugs/food/latex gloves): _____

Are you currently taking any medications (Prescription or Non-Prescription): ***PLEASE LIST***: _____

_____

_____

DENTAL HISTORY

Are you unhappy with the appearance of your teeth? ___ yes ___no
Would you like whiter teeth? ____ yes ___ no Have you had orthodontic treatment? ___ yes ___ no
Have you experienced any growth or sore spots in your mouth? ___ yes ___ no
Do your gums bleed? ___ yes ___ no
Do you have sleep or snoring issues? ___ yes ___ no
Have you ever had any periodontal (gum) treatment? ___ yes ____no
Do you clench or grind your teeth during the day or night? ___ yes ___ no
Do you have headaches, earaches, or neck pains? ___ yes ___ no
Are you apprehensive about your dental treatment? ___ yes ___ no
Any part of your mouth sore to pressures or irritants (cold, sweets, etc.)? ___yes ___no
If so, locate: _____

Previous Dentist: _____ **Date of Last Visit:** _____

Family Physician: _____ **Phone Number:** _____

Preferred Pharmacy: _____ **Phone Number:** _____

FINANCIAL POLICY

Dental insurance is an agreement between you and your insurance company. Insurance only assists and does not relieve one of financial obligations. ***Please be advised we are not a preferred provider or in network with any insurance company other than Delta Dental (premier provider), Cigna (depending on individual plan), United Concordia (depending on individual plan), and Always Care.*** I hereby authorize payment of dental benefits directly to Dr. Bradley M. Stewart. I understand that I am responsible for all charges whether or not they are covered by insurance. The undersigned agrees to pay a collection fee of 33.33% of the total amount owed in the event the account is placed in the hands of or assigned to a third party for collection. The undersigned also agrees to pay all garnishment and/or court fees in the event of default. There will be a $30 service charge for all returned checks. All appointments not cancelled within 24 hours will be charge $25 and may increase with each occurrence.

CONSENT: The undersigned hereby authorizes Bradley M. Stewart DMD to take radiographs, study models, photographs, or any other diagnostic aids deemed necessary by Bradley M. Stewart DMD to make a thorough diagnosis of the patient's dental needs. I also authorize Bradley M. Stewart DMD to perform any and all forms of treatment, medication and therapy that may be indicated. All information on this page and the Medical History form is correct and fully understood by me. I understand the financial policy and assign all insurance benefits, if applicable, to Bradley M. Stewart DMD.

Patient/Parent Signature: _____ **Date:** _____

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice any change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information. You have the right to revoke this consent in writing signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may disclose or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

Please indicate which information you allow to be shared and with whom it may be shared. If no information is allowed to be shared, please sign and date below

IF SOMEONE IS NOT LISTED, THEY CAN'T CALL FOR ANYTHING

☐ Appointments ☐ Treatment ☐ Dental/Medical History ☐ Prescriptions

Name: _____ Relation to Patient: _____

Name: _____ Relation to Patient: _____

Patient Name (PRINT ONLY PLEASE): _____

Signature: _____ Date: _____