Patient Information

Date ____________________

Patient's Name ____________________ Date of Birth ____________________

Marital Status ☐ Single ☐ Married – Name of Spouse ____________________ ☐ Divorced ☐ Widowed

Address ____________________ Home Phone ____________________

City, State, Zip ____________________ Cell Phone ____________________

Person Responsible for Payment ____________________ Business Phone ____________________

SS # of Person Responsible for Payment ____________________ Email ____________________

Employed By ____________________

Business Address ____________________

Driver's License # ____________________

Dental Insurance Plan (if any) ____________________

Subscriber's SS# ____________________ Subscriber's Date of Birth ____________________

Employer Supplying Dental Insurance ____________________

How did you hear about our office? ____________________

Dental History

Reason for today's visit ____________________

Date of last dental exam ____________ Any previous major dental treatment? ☐ Yes ☐ No When? ____________

Date of last full mouth x-ray ____________ Where? ____________________

Medical History

Do you have a history of the following?

☐ Bacterial Endocarditis ____________________

☐ Heart Attack – Year: ____________________

☐ Heart Pacemaker ____________________

☐ High / Low Blood Pressure *(circle one)* ____________

☐ AIDS / HIV ____________________

☐ Artificial Replacements – Year: ____________

☐ Heart Valves – Year: ____________________

☐ Epilepsy / Seizures ____________________

☐ Emotional Problems or Dependencies ____________

☐ Cancer / Radiation ____________________

☐ Diabetes ____________________

☐ Hepatitus (Type) ____________________

☐ Pregnancy ____________________

Do you take aspirin regularly? ☐ Yes ☐ No ____________________

Do you take Blood Thinners such as Plavix, Coumadin, Heparin, etc.? ☐ Yes ☐ No ____________

Do you take Vitamins other than a multi vitamin? ☐ Yes ☐ No ____________________

List any allergies to drugs or anesthetics or latex: ____________________

____

Describe any other medical condition not mentioned above: ____________________

____

List all drugs and medications you are currently taking: ____________________

____

____

Signature: ____________________

Stephen E. Stein, D.D.S.

OFFICE POLICY

Our office policy is that payment is due when services are renderd. We accept the following forms of payment.

CASH CHECK VISA MASTERCARD AMERICAN EXPRESS & DISCOVER

If you have no dental insurance, you will be responsible for paying 50% of the procedure fee when treatment is started and the balance when treatment is completed.

If you have dental insurance, you will be responsible for paying 50% of your estimated portion when treatment is started and the balance of your estimated portion when treatment is completed. You will be billed for the remaining balance once payment has been received from your insurance company that you understand you are responsible for.

We also offer a payment plan through a finance company, for patients who request this service before treatment is started.

I understand that there will be 1.2% interest per month charged on all unpaid balances once my treatment is completed and that I will be responsible for all costs of collections.

I understand that if I miss a scheduled appointment without 24 hour notice, I will be charged a $50.00 fee for the time that was reserved for me.

I give my consent for this office to release my personal health information for the purpose of treatment, payment or healthcare operations.

I reviewed, understand and agree to the guidelines stated above. I have been given the opportunity to ask any questions that I may have had before signing below.

____

PATIENT SIGNATURE DATE

____

PATIENT CORODINATOR DATE

10806 U.S. Highway 19 Suite 101 Port Richey, FL 34668 (727) 863-2497 Fax (727) 862-7862
www.stephenesteindds.com

Stephen E. Stein, D.D.S.

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

STEPHEN E. STEIN D.D.S., P.A., will use your medical information for the following:

TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.

PAYMENT: We will file necessary claims to your insurance companies in your name to obtain payment. They may request part or all of your medical records to pay the claim.

HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire PRIVATE POLICY NOTICE OF STEPHEN E. STEIN D.D.S.,P.A., is posted in the waiting room for your perusal.

In conjunction with these privacy practices you will need to provide us with the following information.

Names of person(s) we may speak to regarding your health, (i.e. spouse,child,etc including phone numbers).

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Signature of Patient or Legal Guardian Relationship to Patient

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Print Patient's Name or Legal Guardian Patient's Date of Birth

____

Date

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