Dr. Neil K Stevenson
12078 San Jose Blvd, Suite 1
Jacksonville, FL 32223
(904) 268-4466

Adult Patient Information

Today's Date: _____

Name:_____ Preferred Name:_____

Date of Birth: _____ Male/Female Social Security Number: _____

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

Would you like an Email and/or Text to confirm appointments? TEXT/EMAIL

Email address: _____

Home Address: _____

_____Zip Code:_____

Employer: _____

Whom may we thank for referring you to our office? _____

Other family members seen by us: _____

Previous Dentist: _____Last Visit date: _____

Marital Status: Single/ Married/ Divorced/ Widowed/ Separated

Spouse's Name: _____ SSN:_____ DOB:_____

Emergency Number: _____ Employer: _____

Who is responsible for the account: _____Relationship:_____

Who is responsible for making appointments? _____Relationship:_____

Primary Dental Insurance Company: _____

Claims Mailing Address :_____

Insurance Company Phone Number: _____Insurance ID: _____

Name of Insured:_____ Insured's DOB:_____

Relationship of insured to patient: _____ Insured's SSN: _____

Insured's Employer: _____

Name:_____

Why are you at the dentist today? _____

How many times do you brush your teeth daily? ____ How often do you floss weekly? _____

Physician: _____ Physician's phone number: _____

HEALTH QUESTIONAIRE:

Current Medications (prescribed & over the counter)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Allergies YES / NO List if Yes

_____ _____

_____ _____

_____ _____

Surgeries (any)

_____ _____

_____ _____

Cancer

Cancer Y / N What Type? _____

What treatment? _____

Dental

Periodontal Treatment (deep cleaning/surgery) Y/N

Premed required before dental appointment Y/N

Are you Happy with your Smile Y/ N

Dry Mouth Y / N TMJ/Joint Pain Y/ N

Ear, Nose, Throat

Sinus Y / N Throat Y / N

Gastrointestinal

Heartburn Y / N Hepatitis ____ Y/ N

Reflux Y / N Colitis Y/ N

Ulcers Y / N Liver disease Y/ N

Immunology

AIDS/HIV Y / N Lupus Y / N

Sjogren's Y / N

Neurological

Stroke Y / N Seizures/Epilepsy Y/N

Shingles Y / N Fever Blisters Y/N

Fainting Y / N Frequent Headaches Y/N

Respiratory

Asthma Y / N Emphysema Y/N

Bronchitis Y / N Tuberculosis Y/N

Your Social History

Tobacco Y / N Alcohol Y / N

Cardiovascular

Mitral Valve Prolapse Y/N Pacemaker Y/N

Low Blood Pressure Y/N High Blood Pressure Y/N

Heart Failure Y/N Heart Attack Y/N

Rheumatic Fever Y/N Murmur Y/N

Endocrine

Thyroid Y / N Diabetes Y / N

Eyes

Glaucoma Y / N Cataract Y / N

Genitourinary

Currently Pregnant Y / N Week?_____

Nursing Y / N Birth Control Y / N

Hematologic

Hemophilia Y / N Transfusion Y / N

Musculoskeletal

Artificial Bone Y / N Artificial Joint Y / N

Have you taken Medicine for Osteoporosis? Y /N

What? _____

Psychiatric

Disorders Y / N What? _____

Alcohol Abuse Y / N Drug Abuse Y / N

Other

_____

_____

Family History

Diabetes Y / N Who? _____

NOTE: **Do you have anything of a personal nature that you need to speak to the Doctor about? Y / N**

I understand that the information that I have given is to the best of my knowledge, that it will be held in strictest of confidence and it my responsibility to inform this office of any changes in my medical status.

Signature of Patient or Guarantor: _____ Date: _____

Name:_____

Financial/Insurance Agreement

Please Initial Below

Payment in full is due at the time of treatment

Methods of Payment: Cash, Check, Visa, MasterCard, American Express and Discover.

If you have insurance:

- At the time of service, you will be asked to pay the deductible **AND** all estimated out-of-pocket costs. We will estimate your insurance coverage and submit the proper forms making our best effort to help you maximize your insurance coverage. *We will bill you for anything not covered by insurance.*
- For extensive or long term treatments you must pay 50% of the estimated out of pocket expenses. Then pay any residuals, not coved by insurance, at follow-up appointment **OR** by pre-arranged financial contract.
- If your insurance pays you directly you must cover **all** services at time of treatment.

Please note that your insurance coverage is a
contract between YOU and the INSURANCE COMPANY,
and that our office is not party to any contract with your insurance company

X_____ I understand that Dr. Stevenson is NOT a Network provider for any insurance company.

X_____I hereby authorize Dr. Neil K. Stevenson to bill my insurance company directly for these services.

If you have NO insurance:

- Full payment is required on the day treatment is rendered.
- For extensive or long term treatments you must pay 50% of the total treatment with balance due at the next follow-up appointment **OR** By pre-arranged financial contract.

Other Charges

X _____ I acknowledge and agree to a $5.00 fee being accessed to my account for each 30 day period the account is past due.

X_____ I acknowledge and agree to being liable for all costs resulting from my account being sent to collections; including but not limited to collection fees, legal costs, lawyer fees, etc.

X_____ I understand that I am responsible for payment of services rendered and also responsible for paying any deductibles and fees that my insurance does not cover.

_____ _____

Patient or authorized person on behalf of patient signature Date

Name:_____

Authorization for Dental Treatment

I authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this authorization and consent, I understand that as a matter of law it shall be conclusively presumed:

A. That the action of my dentist in obtaining this consent form from me is in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided me by my dentist, I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatments or procedures;

OR

B. That I, considering all of the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph A above.

_____ _____

Patient or authorized person on behalf of patient signature Date

Consent for Medical Information Agreement

There are times we are asked to give family members or others information on financial/insurance information or dental treatment, especially if you are not available. If you would like for us to give out information regarding your treatment to your family or friends, please fill in their name and their relationship to you. **Please designate which type of information each person may receive** by checking the items we may release.

Relationship	Name of person	Type of information		
Spouse_____	_____	___ All Information	___Financial/Insurance	___Treatment
Parent_____	_____	___ All Information	___Financial/Insurance	___Treatment
_____	_____	___ All Information	___Financial/Insurance	___Treatment
_____	_____	___ All Information	___Financial/Insurance	___Treatment

☐ **ALL INFORMATION TO BE RELEASED TO PATIENT ONLY**

_____ _____

Patient or authorized person on behalf of patient signature Date

For Office Use Only

Signature of Doctor or Staffed reviewed: _____ Date: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name of Patient: _____

Address: _____

Telephone: _____ Email: _____

Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: *Dr. Neil K. Stevenson* Telephone: *(904) 268-4466* Fax: *(904) 268-5904*

Email: office@stevensonfamilydentistry.com

Address: *12078 San Jose Blvd., Suite 1, Jacksonville, FL 32223*

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of our revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a person representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I,_____ , have received a copy of this office's Notice of Privacy Practices.

_____Please Print Name

_____Signature

_____Date

If this Acknowledgement is signed by a personal representative (parent or guardian) on behalf of the patient, complete the following:

Personal Representative's name_____

Relationship to Patient_____

For Program Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)