Bryan Stephens, D.D.S., Inc

https://www.bryanstephensdds.com/ drbms@sbcglobal.net
60 N. Miller Rd. • Akron, OH 44333 (330)867-7741

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** _____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ ____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ ____ _____
City State Zip Code

Please enter your Employer and Occupation:

_____

_____

Whom may we thank for referring you to our practice? If you found us online, what did you search?

_____

Responsible Party Information

Please enter information for the person financially responsible for the account.

Please indicate the Financially Responsible Party: *

◯ I am financially responsible for this account. (Skip this section and continue to the next section.)

◯ Other: Please fill out the information below.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Dental Insurance Information

If you do not have dental insurance, please mark the "Insurance Authorization" box below and continue to the Dental Health Information section.

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Dental Insurance Company Phone Number: _____

Insurance Authorization:

☐ **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Secondary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Dental Insurance Company Phone Number: _____

Dental History Information

What is the reason for your visit today?

_____

_____

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you having any dental problems now? If yes, please describe.

_____

_____

Previous dentist's name and phone number:

_____

_____

What was done at your last dental visit?

_____

_____

When was your last dental cleaning, exam and x-rays?

_____

_____

How often do you brush your teeth? _____

How often do you floss your teeth? _____

What other dental aids do you use? (Electric toothbrush, toothpicks, floss aids, etc.)

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

Check all that apply:

- ☐ Had complications or a bad experience from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Have dry mouth
- ☐ Gums bleed or hurt when brushing or flossing
- ☐ Snore or wake up frequently during the night
- ☐ Loose teeth
- ☐ Have or had a burning sensation in your mouth
- ☐ Food gets trapped between any teeth
- ☐ Clench or grind your teeth while awake or asleep
- ☐ Change in bite
- ☐ Have pain in the joint, ear or side of face
- ☐ Teeth are sensitive to hot, cold, biting, chewing or sweets
- ☐ Hold foregin objects with your teeth
- ☐ Had a serious injury to the mouth or head
- ☐ Wear, or have worn, a bite splint or night guard
- ☐ Had Periodontal Treatment
- ☐ Had trouble getting numb
- ☐ Anxious about dental treatment
- ☐ Have difficulty chewing or either side of the mouth
- ☐ Have or had an unpleasant taste or odor in your mouth
- ☐ Frequently get cold sores, blisters or any other oral lesions
- ☐ Have or had gum recession
- ☐ Parents experienced gum disease or tooth loss
- ☐ Have popping and/or clicking of the jaw
- ☐ Have tired jaws, especially in the morning
- ☐ Had teeth ground/ bite adjusted
- ☐ Have difficulty in opening or closing the mouth
- ☐ Bite lips or cheeks regularly
- ☐ Mouth breathe while awake or asleep
- ☐ Do you, or have you, whitened or bleached your teeth
- ☐ Had or have braces (orthodontic treatment)
- ☐ Had Oral Surgery

Would you like to change the appearance of your smile? If yes, please explain below. * ◯ Yes ◯ No

If any of the checked boxes need further explanation, please describe:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

☐ * **By checking this box, I understand the above information and agree with its contents. This will serve as my electronic signature for the Administration Form.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I authorize this office to disclose or discuss my personal and/or dental information with the following person(s).

(Please enter name and relationship to patient.)

_____

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form.**

Name of person filling out this form: *

_____

_____

Relationship to patient: *

☐ Self ☐ Parent ☐ Step-parent ☐ Grandparent ☐ Legal Guardian ☐ Other

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Response Date: _____

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Medical History

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ **Premed	☐ *Allergy: Latex	☐ Allergy: Penicillin	☐ Alzheimer's/Dementia
☐ Anemia	☐ Arthritis/Rheumatism	☐ Artificial Joints	☐ ArtificialHeartValve
☐ Asthma	☐ Blood Disease	☐ Blood Transfusion	☐ Bruise Easily
☐ Cancer	☐ Chemo / Radiation	☐ Chest Pain	☐ Chronic Cough
☐ ColdSores/FeverBlist	☐ Contact Lenses	☐ COPD	☐ Diabetes
☐ Dizziness / Fainting	☐ Emphysema	☐ Epilepsy/Seizures	☐ Excessive Bleeding
☐ Glaucoma	☐ Hay Fever	☐ Head Injuries	☐ Heart Attack
☐ Heart Murmur	☐ Heart Surgery	☐ Hemophilia	☐ Hepatitis
☐ High Blood Pressure	☐ HIV / AIDS	☐ Jaundice	☐ Kidney Disease
☐ Kidney Trouble	☐ Liver Disease	☐ Mitral ValveProlapse	☐ Nervous/Anxious
☐ NeurologicalDisorder	☐ On Blood Thinners	☐ Pacemaker	☐ Parkinson's Disease
☐ Psychiatric Care	☐ Psychological Care	☐ Respiratory Problems	☐ Restricted Diet
☐ Rheumatic Fever	☐ Sickle Cell Disease	☐ Sinus Problems	☐ Sleep Apnea
☐ STD / HPV	☐ Stomach Problems	☐ Stroke	☐ Thyroid Problems
☐ Tuberculosis	☐ Tumors	☐ Ulcers	☐ xOther Explain Below

☐ FEMALE: Pregnant or Planning Pregnancy ☐ FEMALE: Nursing

If any conditions or alerts selected above need further clarification, please describe below (including due date if pregnant):

_____

_____

What is your estimate of your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you smoke, vape, or use chewing tobacco? Please check all that apply.

☐ Smoke ☐ Vape ☐ Chew

Do you take antibiotic PREMEDICATION (premed) for your dental visits? If yes, please explain below. (Give date of surgery, or date you were diagnosed with the condition for which you premed. Also, tell us what you take and how it is taken. For example: Amoxicillin 500mg, 4 tablets 1 hour before dental appointment.) *

◯ Yes ◯ No

PREMEDICATION

_____

_____

MEDICATIONS Are you taking any prescription OR non-prescription medications, including regular doses of aspirin or birth control pills? If yes, please list below. *

◯ Yes ◯ No

Please list any medications you are currently taking, one medication per line:

Have you, or are you taking any Bisphosphonate drug used to treat osteoporosis or Paget's disease? Examples; Fosamax, Actonel, Boniva, Reclast, Didronel, Zometa, Prolia etc. If yes, please enter the drug in the medication list above. *

◯ Yes ◯ No

Have you ever taken prescription medications for weight-loss (diet pills) such as Fen-Phen (Fenfluramine-Phentermine), Pondimen (Fenfluramine) or Redux (Dexfenfluramine)? If yes, please list in medication list above. *

◯ Yes ◯ No

If you have taken any of the above (diet pills), did you have a medical exam for heart issues? ◯ Yes ◯ No

ALLERGIES Do you have any allergies (including allergies to medications)? If yes, please list below: * ◯ Yes ◯ No

Name of your primary care physician and phone number:

Date of your last visit: _____

Name and phone number of preferred pharmacy:

In an emergency who should be notified? Please enter name and phone number below:

Describe any current medical treatment, recent hospitalizations and any recent or upcoming procedures/surgeries below:

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes. This will serve as my electronic signature.**

Response Date: _____

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COVID-19 Patient Screening Form

If you answer YES to any of these Questions, please explain in the box provided.

Patient Name: _____ * _____ * ____ _____

Last First MI Preferred Name

IN OFFICE USE ONLY Body Temperature _____

Have you received a COVID-19 Vaccine? * ◯ Yes ◯ No

Check which you have received: *

◯ None ◯ 1st Vaccine ◯ 1st & 2nd Vaccine ◯ Johnson & Johnson Vaccine

Do you have a fever or have you felt hot or feverish recently (within the past 14-21 days)? * ◯ Yes ◯ No

Are you having any shortness of breath or other difficulties breathing? * ◯ Yes ◯ No

Do you have a cough or a sore/scratchy throat? * ◯ Yes ◯ No

Have you had any flu-like symptoms, such as gastrointestinal upset, headache or fatigue within the past 14-21 days? * ◯ Yes ◯ No

Have you experienced recent loss of taste or smell? * ◯ Yes ◯ No

Are you, or have you been, in contact with any confirmed COVID-19 positive patients? If yes, provide the date of last contact with the person(s): *

◯ Yes ◯ No

Have you been in contact with anyone within the last 14-21 days who has been ill or who has had a fever? * ◯ Yes ◯ No

Response Date: _____