Stevenson Dental
6905 E. 96th Street, Suite 800
Indianapolis, IN 46250
(317) 849-6990

Contact Information

Patient Name _____ Birth date _____/_____/_____
Last First MI
Full Name of Spouse or Parent, if child _____
Last First MI

Driver's License Number _____ Social Security No. _____-_____-_____
Address _____ Phone (_____)_____-_____
City _____ State ____ Zip Code _____ Cell (_____)_____-_____
Email Address _____

In case of emergency, who may we contact:
Contact name _____ Phone (_____)_____-_____

How did you hear about us? (Please circle one)
Family/ Friend Insurance Carrier Advertising Other – Please state _____
If family or friend, who may we thank for referring you? _____

Insurance Information

Policy Holder _____ Birth date _____/_____/_____
Last First MI
Relation to Patient _____ Social Security No. _____-_____-_____
Address(if different from patient) _____
City _____ State ____ Zip Code _____ Phone (_____)_____-_____
Employer _____ Occupation _____
Business Address _____ Phone (_____)_____-_____
_____

Insurance Company/Plan Name _____
Contract #_____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

Is patient covered by additional insurance? Yes No
Policy Holder _____ Birth date _____/_____/_____
Last First MI
Relation to Patient _____ Social Security No. _____-_____-_____
Address(if different from patient) _____
City _____ State ____ Zip Code _____ Phone (_____)_____-_____
Employer _____ Occupation _____
Business Address _____ Phone (_____)_____-_____
_____

Insurance Company/Plan Name _____
Contract #_____ Group # _____ Subscriber # _____
Names of other dependents covered under this plan _____

Stevenson Dental
6905 E. 96th Street, Suite 800
Indianapolis, IN 46250
(317) 849-6990

Authorization for Treatment

1. To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.
2. I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. All procedures have risks. These include, but are not limited to: Drug reaction/side effects; damage to adjacent teeth or fillings; post operative sensitivity to temperature and/or pressure; bruising/pain/swelling; failure of dental procedure, necessitating additional treatment; complications during treating, necessitating referral to a specialist.
3. I authorize and consent to any x-rays, examination, anesthetics, sedative, or dental treatment rendered for myself and/or children under the general, direct or indirect supervision of Dr. Mark R. Stevenson.
4. I authorize photographs, x-rays and other records made during the course of my examination, treatment, and follow-up care to be used for purposes of research, education or publication in professional journals.
5. I understand that diagnostic radiographs are necessary to ensure optimum dental health. I will not hold Stevenson Dental or Dr. Mark R. Stevenson liable for any failure to diagnose, or any misdiagnosis due to my refusal for recommended x-rays. I will take full responsibility for any conditions relating to my dental health that may not have been diagnosed or misdiagnosed due to lack of radiographs.
6. I hereby release from liability Stevenson Dental and Dr. Mark R. Stevenson and his employees and agents from injury that I may currently, or in the future, suffer as a result of my refusal to proceed with any recommended dental treatment by Dr. Mark R. Stevenson.

Financial Consent

1. I authorize release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluation and administering insurance benefits.
2. I hereby authorize payment of insurance benefits directly to the dentist or dental groups, otherwise payable to me.
3. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine and are due and payable at the time services are rendered, unless previous arrangements have been made. I agree to pay any collection or court costs incurred.
4. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I attest to the accuracy of the information on these pages, and I agree with all Authorizations and Consents listed above.

_____ Date _____
Signature of Patient or Parent/Guardian

Acknowledgment of Receipt of Notice of Privacy Practices

I, (print name) _____, have received a copy of this office's Notice of Privacy Practices. I understand that I may refuse to sign this acknowledgment.

_____ Date _____
Signature of Patient or Parent/Guardian

Stevenson Dental
6905 E. 96th Street, Suite 800
Indianapolis, IN 46250
(317) 849-6990

Patient Name _____ Birth date _____/_____/_____
Last First MI

Medical History

Name of Physician _____ Phone (_____) _____-_____
Date of last exam _____Do you have a current medical problem? ..... Yes / No
If yes, please explain _____
_____
Have you had any serious illnesses or operations? ..... Yes / No
If yes, please explain_____
_____
Have you ever had any excessive bleeding requiring special treatment? ..... Yes / No

CONDITIONS - Circle any of the following which you have had or have at present:

Heart failure	Artificial Joint	Thyroid Disease	Blood transfusion
Heart Disease/Attack	Anemia	X-ray or Cobalt Treatment	Drug Addiction
Angina Pectoris	Stroke	Cancer – Chemo/Radiation	Hemophilia
High Blood Pressure	Kidney Trouble	Arthritis	Venereal Disease
Congenital Heart Failure	Ulcers	Rheumatism	Cold Sores
Heart Surgery	Emphysema	Cortisone Medicine	Genital herpes
Heart Pacemaker	Tuberculosis (TB)	Glaucoma	Epilepsy or Seizures
Heart Stent	Asthma	HIV/AIDS	Fainting or Dizzy Spells
Artificial Heart Valve	Hay Fever	Hepatitis A (infectious)	Nervousness
Mitral Valve Prolapse	Sinus Trouble	Hepatitis B (Serum)	Psychiatric Treatment
Diabetes	Allergies or Hives	Liver Disease	Yellow Jaundice

Do you have any disease, condition, or problem not listed? ..... Yes / No
If yes, please explain _____
_____
MEDICATIONS - Please list any medications you are currently taking (or attach a list): _____
_____
_____
Are you taking or have you ever taken a drug to treat Osteoporosis? …… Yes / No
Have you ever taken Fossamax, Boniva, Zometa, Actonel, Alclasta or any other bisphosphonate drug?.. Yes / No

ALLERGIES - Please list any allergy and type of reaction (i.e. itching, rash, swelling, vomiting, etc):
_____
_____

Women only:
Are you pregnant or nursing?..... Yes / No Due Date _____
Are you using hormones? ..... Yes / No Type_____
Are you taking birth control? ..... Yes / No Type_____

To the best of my knowledge, all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, I will inform the doctor at the next appointment without fail.

Patient (Guardian) Signature _____ Date _____

Reviewed _____	Updated _____	Updated _____	Updated _____
Date _____	Date _____	Date _____	Date _____

Stevenson Dental
6905 E. 96th Street, Suite 800
Indianapolis, IN 46250
(317) 849-6990

Patient Name _____ Birth date _____/_____/_____
Last First MI

Dental History

Reason for today's visit _____
Any pain? ..... Yes / No If yes, where? _____

If new patient, name of former dentist _____ Last date(or year) treated _____
Last date of complete series of dental x-rays _____
Consent to contact of former dentist for patient history and/or x-rays ..... Yes / No

Have you ever had.....	Orthodontic Treatment?.....	Yes / No	..... Braces	Year _____
	Oral Surgery?	Yes / No	..... Extractions.....	Year _____
	Periodontal Treatment?	Yes / No	Gum Treatment	Year _____
	Your bite adjusted?	Yes / No		
	A bite plate or other appliance?	Yes / No		

Have you noticed any loosening of your teeth? ..... Yes / No
Does food tend to become caught between your teeth? ..... Yes / No ..... Where? _____
Do your gums often bleed when you brush your teeth? ..... Yes / No

Have you ever experienced	Clicking of the jaw?	Yes / No
	Pain (joint,ear, side of face)?.	Yes / No
	Difficulty opening/closing?...	Yes / No
	Difficulty chewing?.....	Yes / No

Do you.....	Clench or grind your teeth while awake or asleep?	Yes / No
	Bite your lips or cheeks regularly?	Yes / No
	Hold foreign objects with your teeth(pencils, pens, pipe, nails)?	Yes / No
	Mouth breathe while awake or asleep?	Yes / No
	Snore?	Yes / No

Do you feel very nervous about having dental treatment? ..... Yes / No
Have you ever had nitrous oxide analgesia (laughing gas) administered? ..... Yes / No

Have you ever had an upsetting experience in the dental office? ..... Yes / No
If yes, please explain _____
_____

Are you satisfied with the appearance of your teeth and smile? ..... Yes / No
If no, what is not satisfactory? _____
_____

Any dental concerns not listed above? Please explain. _____
_____
_____