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

Print Name _____ Signature _____ Date _____

For office 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
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please specify)

CHAD E STEPHENSON, DDS PC
409 NE GREENWOOD AVENUE SUITE 100, BEND, OREGON 97701
2300 SW GLACIER PL. REDMOND, OREGON 97756

Thank you for visiting Juniper Dental. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____ (FIRST / MIDDLE / LAST / NICKNAME)

Address _____ (STREET)

_____ (CITY / STATE / ZIP)

Employer _____ Drivers License _____

Birth date _____ ❑ Male ❑ Female ❑ Single ❑ Married ❑ Other

Phone: Home _____ Social Security # _____

Work _____ May we contact you at work? ❑ Yes ❑ No

Mobile _____

Email _____ May we send email communication? ❑ Yes ❑ No

Emergency: Name _____ Phone _____

Insurance

Primary Dental Carrier

Subscriber Name _____ Insurance ID # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Secondary Dental Carrier

Subscriber Name _____ Social Security # _____ DOB _____

Employer _____ Insurance Co. _____

Insurance Co. Phone # _____ Group # _____

Relation to patient _____

Insurance Authorization Statement (Sign & Date)

I hereby authorize payment directly to Chad E Stephenson DDS PC (ABN "Juniper Dental") of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature _____ **Date** _____

If Patient is Under 18

Responsible Party _____ Relation to Patient _____

Address _____ (STREET)

_____ (CITY / STATE / ZIP)

Telephone _____

Other Information

How did you hear about us? _____

What was the reason for today's visit? _____

Do you love your smile? _____

Is there anything you would like to change? _____

Why did you leave your last dentist? _____

What did you like *most* about your last dentist? _____

Medical History and Information

Conditions

Y	N		Y	N	
❑	❑	Abnormal bleeding	❑	❑	Heart Murmur
❑	❑	Alcohol Abuse	❑	❑	Heart Surgery
❑	❑	Allergies	❑	❑	HIV+/AIDS
❑	❑	Anemia	❑	❑	Hepatitis A/E
❑	❑	Angina	❑	❑	Hepatitis B
❑	❑	Arthritis	❑	❑	Hepatitis C
❑	❑	Artificial heart valve	❑	❑	High Blood Pressure
❑	❑	Asthma	❑	❑	Joint Replacement
❑	❑	Blood transfusion			When _____
❑	❑	Cancer _____	❑	❑	Kidney problems
❑	❑	Chemotherapy	❑	❑	Liver disease
❑	❑	Colitis	❑	❑	Mitral valve prolapse
❑	❑	Congenital heart defect	❑	❑	Pacemaker
❑	❑	Diabetes Type 1___ 2___	❑	❑	Psychiatric Conditions
❑	❑	Difficulty breathing	❑	❑	Radiation Therapy
❑	❑	Dementia	❑	❑	Rheumatic Fever
❑	❑	Drug abuse	❑	❑	Shingles
❑	❑	Emphysema	❑	❑	Sickle Cell
❑	❑	Epilepsy/Seizures	❑	❑	Sinus problems
❑	❑	Facial Surgery	❑	❑	Stroke
❑	❑	Fainting Spells	❑	❑	Thyroid Problems
❑	❑	Fever Blisters	❑	❑	Tuberculosis
❑	❑	Glaucoma	❑	❑	Ulcers
❑	❑	Headaches/Migraines	❑	❑	Other _____
❑	❑	Heart Attack			_____

Medical Allergies

Y	N	
❑	❑	Codeine
❑	❑	Dental Anesthetics
❑	❑	Erythromycin
❑	❑	Latex
❑	❑	Metals
❑	❑	Penicillin/Amoxicillin
❑	❑	Sulfa
❑	❑	Tetracycline
❑	❑	Other _____

Drug Use

Y	N	
❑	❑	Cigarettes?
❑	❑	Chewing Tobacco?
❑	❑	Marijuana?

If Female

Y	N	
❑	❑	Are you taking Birth Control Pills? _____
❑	❑	Are you pregnant? If yes, # of weeks
❑	❑	Are you Nursing?

List current medications (including OTC): _____

_____

Physician name: _____ Physician number: _____

For office use only

Medical history reviewed by: ____ Date: _____ Comments: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition. Payment for all treatment and services rendered are my responsibility.

_____ _____

PATIENTS SIGNATURE DATE

If patient is a child or requires a guardian:

_____ _____

PARENT/GUARDIAN SIGNATURE DATE

CHAD E STEPHENSON, DDS PC
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Consent to Dental Procedures, Administration of Anesthetics, Sedatives and the Rendering of Other Services

Patient: _____ Age: _____

1. I hereby authorize Dr. Stephenson and his assistants as may be selected, to perform Routine Dental Care upon the above named and/or any other therapeutic procedure that his/her/their judgment may dictate to be advised for the patient's well being.

2. The nature and purpose of the procedure and anesthetic, the risks involved, and the possibility of complications has been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The advantages and inherent risks of anesthesia and sedation have been explained to me and I authorize the administration of such anesthesia and sedation as may be considered necessary or desirable.

3. I authorize that any specimens, tissue or parts removed from the patient may be disposed of in accordance with established practice.

4. I further authorize the performance by any qualified person of any other services which are deemed to be necessary or advisable.

5. If in Dr. Stephenson's opinion, further observation of the above named is indicated after an anesthetic or procedure, the above named agrees to be transported by ambulance at his/her expense to a mutually satisfactory hospital in the local area and to be admitted for observation and any necessary treatment.

6. If in Dr. Stephenson's opinion, the above named required the services of a specialist, he/she agrees to accept the referral and will be responsible for any expenses that may be incurred.

7. I certify that I have read this Consent, or that it has been read to me, and that I understand the above. The nature and purpose of such operation(s), procedure(s), treatment(s), and/or services and the reasons why the same is (are) considered necessary or advisable have been explained to me.

Signature of Patient or Legal Guardian Date

CHAD E STEPHENSON, DDS PC
409 NE GREENWOOD AVENUE SUITE 100, BEND, OREGON 97701
2300 SW GLACIER PL. REDMOND, OREGON 97756

Financial Policy

Payment in full is due at time of treatment

Payments are expected at the time services are rendered. We accept cash, checks (under $500.00), debit cards, and all major credit cards. As a patient, or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office as stated above. There is no interest or finance charge on current accounts. After 30 days, all accounts are subject to Finance Charges of 1.5% of the unpaid balance which is an Annual Percentage Rate (APR) of 18%. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release the information necessary to secure payment.

Dental Insurance

Payment of your percentage of insurance coverage is due at the time of treatment. As a courtesy to our patients, we will bill your insurance. Any insurance benefits quoted are an estimate and not a guarantee of insurance payment. However, if there is no payment from your insurance company to our office within 60 days, or payment is lower than the total bill, you will be responsible for the balance in full at that time. We are not able to negotiate with your insurance company on your behalf.

Optional Payment Terms

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care. We are always available to answer your questions or assist you in any way we can.

To maintain the practice operations and prevent potential misunderstandings, we ask patients to accept and adhere to the following financial arrangements regarding their dental treatment.

1. **Major Service - Two Payment Option**: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.

2. **Term Loan**: By arrangement with Care Credit, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

Broken appointments

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24 hours notice to avoid a $35.00/hour cancellation fee (emergencies are an exception).

Signature of Patient or Legal Guardian Date

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Financial Policy

We may disclose your health information to a family member, personal representative, or friend other person to the extent necessary to help with your healthcare or with payment for your healthcare, **but only if you agree that we may do so.** Please list the individuals below who have your permission to share your health information:

NAME	**RELATIONSHIP TO PATIENT**

_____ Financial/ Account information

_____ Treatment information

_____ Insurance information

Signature of Patient or Legal Guardian Date