David W. Stover, D.D.S.,LLC

9450 Pennsylvania Ave Suite 17 Upper Marlboro, MD 20772

301-599-1810 | 301-599-1592 | www.davidwstoverdds.com

PATIENT INFORMATION

Date:__________ Patient Name:______________________________ Birthdate:________________

Home Phone:________________ Work Phone:__________________ Cell Phone:________________

Address:____

City:______________________ State:_______ Zip Code:_____________

Email Address:____

Whom may we thank for referring you:____

Person to contact in case of an emergency:______________________________ Phone:_______________

Responsible Party

Person responsible for this account:_____________________ Relationship to patient:_______________

Drivers license#:____________________ Birthdate:______________ Phone:___________________

I understand and agree that I am financially responsible for any chargers to this account and I further agree in the event of non-payment; to be responsible for the cost of collections, and or court costs and reasonable legal fees should this be required.

Signature:____ Date:__________________________

Are you having pain or discomfort at this time?____

Are you being treated by a physician?____

When were you last seen by a dentist?____

Have you ever experienced a problem with local anesthesia?__________________________________

Have you experienced excessive bleeding requiring special treatment?___________________________

List any allergies you may have:____

List all medications, vitamins or supplements that you are taking: ______________________________

____

Ladies, are you pregnant or nursing an infant?____

Have you ever been diagnosed as having periodontal disease(gum disease)?__________________

Do your gums bleed when you brush your teeth?______________________________

Are you aware of any loose teeth?______________________________________

Are you aware of any cracked or broken teeth?______________________________

Do you clench or grind your teeth?______________________________________
Are your teeth sensitive to pressure , heat, cold, air, or sweets?__________________

Have you ever had orthodontic treatment?__________________________________

Are you aware of any swelling or other abnormality in your mouth?__________________

Have you ever had TMJ treatment?_______________________________________

Do you have pain or clicking when opening or closing your mouth?__________________

Please indicate if any member of your family has or has had any of the following:

Heart Disease: ____________ Diabetes:____________ Periodontal Disease:____________

Stroke:____________

Please circle any of the following that you have or have had:

Heart Failure	Asthma	AIDS	Epilepsy
Heart Disease	Diabetes	HIV	Nervousness
Angina Pectoris	Tuberculosis	Hepatitis	Psychoses
Hypertension	Pneumonia	Syhilis	Addiction
Rheumatic fever	Cancer or Tumor	Gonorrhea	Seizures
Scarlet Fever	Emphysema	Candidiasis	Fainting
Pacemaker	Sinus/hayfever	Blood Transfusion	Mitral Valve Prolapse
Osteoporosis	Osteopenia	Rheumatism	Depression
Prosthetic Valve	Allergies	Cortisone	Lightheadedness
Prosthetic Joint	Glaucoma	Sickle Cell	Cold Sores
Stroke	Kidney Disease	Leukemia	Anemia
Diverticulitis	Colitis	Platelet Disorder	Mumps
Thyroid	Nose Bleeds	Skin Disease	Measles

The information given above is true and accurate to the best of my knowledge. Should there be a change in my health status I will inform the doctor at my next appointment without fail. I hereby give my consent to perform necessary diagnostic test and evaluation of my dental health.

Our office policy is there will be a charge of $75.00 for a canceled and or missed appointment without 48 hours notice.

Signature:______________________________ Date:____________________

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The Department of Health and Human Services has established a "Privacy Rule" to help insure that Personal Health Information (PHI) is protected for privacy. The Privacy rule was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures PHI for treatment, payment and health care operations.

As a patient of Dr. David W. Stover we want you to know that we respect the privacy of your medical records and strive to take reasonable precautions to protect your privacy. When it is appropriate we provide the minimum necessary information only to those who we feel are in need of your health care information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

We also want you to know we support your full access to your medical records upon written request.

We may have indirect treatment relationships with you (such as laboratories, radiology services etc.) and may have to disclose PHI for the purpose, treatment and health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your PHI, but this must be in writing. Under this law, Dr. Stover has the right to refuse to treat you should you choose to refuse to disclose your PHI. If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on a previously signed consent.

If you have any objections to this form, please ask to speak to our HIPPA Compliance Officer.

You have the right to review our Notice or Privacy Practices, to request restrictions and revoke consent in writing after you have reviewed our Notice of Privacy Practices.

Print Name:____ Date:______________________

Signature:____

Please List all if any name of persons you authorize release of information to

____