Stepka Family Dental

Providing the best dental care for your family, from ours, since 1973.

Welcome to our office! We appreciate the trust and confidence that you have placed in us and we look forward to meeting you personally and professionally.

Our philosophy of care governs everything that we do for you. The following are the key elements:

- ✓ We truly care about our patients and want you to feel comfortable with our entire staff.
- ✓ We recognize that each patient is unique and our goal is to help you retain your teeth in comfort, function and aesthetics for a lifetime.
- ✓ We work only with one patient at a time and do not double book. The time that you reserve with us is yours and yours alone. We ask that you please call our office to let us know if you are running late for your appointment and if you need to reschedule your appointment, please give at least 24 hours notice.
- ✓ We strive to be thorough in everything we do, taking the time to be the best we can be.

During your first visit, we will take the time to get to you know you (and you, us) and discuss your dental needs and desires.

Enclosed you will find your new patient information form. Please fill this out and bring it with you to your first appointment, along with a list of any medications you take.

We look forward to meeting you,

Sincerely,

Dr. Gregory P. Stepka and Staff

Please visit our web site at StepkaFamilyDental.com to learn more about us!

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401-766-9857 | info@stepkafamilydental.com
StepkaFamilyDental.com

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Patient Information & Health History

Patient's Name: _____ Date of Birth: _____/_____/_____

Patient's Address: _____ Phone: (_____)_____
Street City State Zip

Email: _____ Cell Phone: (_____)_____ Marital Status: _____

Person responsible for this account: _____Relationship_____

Occupation: _____ Employed By: _____

Business Address: _____ Business Phone: (_____)_____

Dental Insurance Plan: _____ Patient's Social Security #: _____

How did you hear about us? ☐ Referred by: _____ ☐ Internet ☐ Other: _____

Dental History

Date of last dental exam: ____/_____/_____ Any previous major dental treatment? ☐ No ☐ Yes _____
[date & procedure]

What is the reason for your dental visit today? _____

How do you feel about your smile? _____

Medical History

Physician's Name: _____ Date of last physical examination: _____/_____/_____

Do you have or have you ever had any of the following diseases or conditions, please mark with a ☑:

☐ **Allergies to any drugs (list below)**	☐ Chronic Fatigue Syndrome	☐ Sinus problems
_____	☐ Asthma	☐ Immune system disorders (AIDS, HIV)
☐ Any joint replacement: Date:_____	☐ Hay fever/ allergies	☐ Stroke
☐ Any heart ailments, congenital heart disease	☐ Latex sensitivity	☐ Thyroid problems
☐ High blood pressure	☐ Diabetes	☐ Tonsillitis
☐ Endocarditis	☐ Kidney problems	☐ Eye disorders
☐ Prosthetic heart valve	☐ Liver problems or Hepatitis	☐ Tuberculosis
☐ Excessive bleeding from cut or extraction	☐ Cancer	☐ Ulcer or Colitis
☐ Anemia or blood problems	☐ Radiation/Chemotherapy treatments	☐ Venereal disease (herpes, syphilis)
☐ Arthritis	☐ Rheumatic Fever	☐ Currently pregnant, month: _____

Describe any current medical treatment **including medications taken**, even if not listed above: _____

_____

Are you currently taking any Bisphosphonates? (i.e.: Fosamax, Boniva, Actonel, Zometa, Aredia) ☐ No ☐ Yes: _____

Office Policies

Appointments: A $30 charge will be made for missed appointments or those cancelled without prior notification of 24 hours. This fee covers only a portion of the overhead such as salaries, electric, heat, etc., which still has to be paid whether you are present or not. Once an appointment is made, please remember this time has been reserved for you.

Insurance: To avoid misunderstandings regarding dental insurance, patients should understand that all professional services rendered are charged directly to the patient and that patients are personally responsible for payment of fees. We will prepare necessary forms or reports to help you obtain your benefits from insurance companies, upon receipt of full (or partial) payment of bill. We do not render our services on the basis that insurance companies will pay all of our fees. As a patient, you are responsible for understanding your unique policy with your insurance provider.

Notice of Privacy Practices: I, _____, have had full opportunity to read and consider the contents of this Consent form and Stepka Family Dental's Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the 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 personal representative on behalf of the patients, please 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