Wm. G. "Steve" Stephens, D.D.S. *Kenneth J. Bevan, D.D.S.*

Family, Cosmetic and Implant Dentistry

2801 Townsgate Road, Suite 205 • Westlake Village, CA 91361 • Phone: (805) 494-3231 • Fax: (805) 494-3241

Welcome to our office! The information requested on this and the following pages is necessary for your treatment. Our records are kept strictly confidential. Thank you for your thoroughness and honesty in answering these questions.

NAME (☐/☐./☐/☐./☐) _____
last first m.i.

ADDRESS _____
street apt. #

_____
city state zip

PHONE Home (_____)_____ Office (_____)_____

Cell (_____)_____ E-mail _____

Where shall we contact you to confirm your appointments?__HOME__OFFICE__CELL__OTHER_____

DATE OF BIRTH _____ Male☐ Female☐ SOC. SEC. # _____ - _____ - _____

EMPLOYER _____ OCCUPATION _____

EMPLOYER ADDRESS _____

PERSON RESPONSIBLE FOR THIS ACCOUNT _____

ADDRESS OF RESPONSIBLE PERSON _____

MARITAL STATUS __ __ __ __ SPOUSE'S NAME _____

SPOUSE'S OCCUPATION _____ SPOUSE'S EMPLOYER _____

SPOUSE'S BUSINESS PHONE (_____)_____ SPOUSE'S CELL PHONE (_____)_____

WHOM MAY WE THANK FOR REFERRING YOU? _____

DENTAL INSURANCE

Primary Coverage _____ Employee Name _____

Employee S.S.N. _____ - _____ - _____ Group # _____ Empl Date of Birth_____

Secondary Coverage _____ Employee Name _____

Employee S.S.N. _____ - _____ - _____ Group # _____ Empl Date of Birth_____

EMERGENCY NOTIFICATION

Name _____ Address _____

Phone: Home (_____)_____ Off. (_____)_____ Cell (_____)_____

Relationship to Patient _____

CONSENT

I, the undersigned, hereby authorize Doctor or his agents to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of Patient's dental needs. I also authorize Doctor or his agents to perform any and all forms of treatment, medication and therapy that may be indicated. I understand that the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event that credit is extended, I authorize this office to check my credit history. I understand that if my account is 90 days past due, I will incur a service charge of 1% (one percent) monthly until the balance is paid. In the event of default on my account, I promise to pay this interest on the indebtedness, together with such collection costs and reasonable attorney's fees as may be required to effect collection of this note.

Patient Signature _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship _____

Dentist's Signature _____ Date _____

PATIENT INFORMATION