PATIENT REGISTRATION

Wellness Dental Date_____

Patient Name _____ Birthdate / / Age
First Middle Last

SS#_____ DL#_____ Occupation _____Work # (____) _____

Marital Status: Single___ Married___ Divorced___ Widowed___ Spouses Name: _____ Work # (____) _____

Home Address_____City/St_____ Zip _____

Home Number (____) _____ Cell Phone (____) _____ Work # (____)_____

Fax # (___) _____ E- Mail Address _____

Employer Name and Address _____

Person Responsible for Account_____Relationship _____

Social Security # _____DL#_____Home # (___)_____

Home Address (if different)_____Zip_____

Employer & Address_____

Occupation_____Work # (___)_____

Do you have Dental Insurance? Yes _____ No_____ With Whom?_____

Preferred contact method (E-mail, cell phone, home phone)? _____

Circle yes or no to the following questions:

1. Are you presently under the care of a physician? ..... Yes No
2. Have you ever had high/low blood pressure? ..... Yes No
3. Has a physician ever said you had heart trouble? (Ex: Artificial heart valve, Heart attack, Pace maker, Angina Pectoris) ..... Yes No
4. Do you have Mitral Valve Prolapse or Congenital Heart Defect? ..... Yes No
5. Have you ever had abnormal bleeding following a cut or extraction? ..... Yes No
6. Have you ever had an anesthetic (either local or general)? ..... Yes No
7. Has a physician or dentist ever said you had a tumor or cancer? ..... Yes No
8. Are you taking any osteoporosis medications? ..... Yes No
9. Are you allergic to Penicillin, Novocain or any other medicine? ..... Yes No
   If so, what? _____
10. Is the patient allergic to anything other than medicine? (e.g. latex or metals)? ..... Yes No
    If so, what? _____

Do you have or ever had:

1. Rheumatic fever? ..... Yes No
2. Rheumatic heart disease? ..... Yes No
3. Anemia, leukemia or low platelets ..... Yes No
4. Epilepsy or convulsions? ..... Yes No
5. Asthma or hay fever? ..... Yes No
6. Tuberculosis ..... Yes No
7. Diabetes? How long ..... Yes No
8. Kidney trouble? ..... Yes No
9. Liver trouble or jaundice? ..... Yes No
10. Thyroid trouble or goiter? ..... Yes No
11. Syphilis? ..... Yes No
12. Fainting or dizziness? ..... Yes No
13. Glaucoma? ..... Yes No
14. Arthritis? ..... Yes No
15. HIV AIDS? ..... Yes No
16. Stroke? ..... Yes No
17. Stomach ulcer? ..... Yes No
18. Heart murmur? ..... Yes No
19. Prostate trouble? ..... Yes No
20. Hepatitis A, B, C or D ..... Yes No
21. Eczema or hives? ..... Yes No
22. Psychiatric treatment? ..... Yes No
23. Are you pregnant? .....How many months_____ Yes No
24. Alcohol abuse ..... Yes No
25. Recreational Drug use ..... Yes No
26. Blood Transfusion ..... Yes No
27. Emphysema ..... Yes No
28. Frequent Headaches ..... Yes No
29. STD's ..... Yes No
30. Chemo or Radiation Therapy ..... Yes No
31. Joint Replacement ..... Yes No
32. Fever Blisters or Shingles ..... Yes No
33. Colitis ..... Yes No
34. Facial Surgery ..... Yes No
35. Difficulty Breathing ..... Yes No
36. Sickle Cell Disease ..... Yes No
37. Seizures ..... Yes No

Are you now taking:

1. Drugs for high blood pressure? ..... Yes No
2. Drugs for sleep? ..... Yes No
3. Cortisone, steroids or ACTH? ..... Yes No
4. Anticoagulants or blood thinner? ..... Yes No
5. Tranquilizers or sedatives? ..... Yes No
6. Antibiotics? ..... Yes No
7. Insulin? ..... Yes No
8. Have you ever taken Fen-Phen? ..... Yes No
9. Others? ..... Yes No
10. List any questions:_____

11. Have you been under the care of a physician for any major illness or injury other than those noted above. If so, list.

I Understand That Payment Is Due At Time Of Service.

I will pay today by: ❑ CASH ❑ CHECK ❑ CREDIT CARD

Signature_____**Date**_____

Our office is committed to meeting or exceeding the standards of infection control mandated by the OSHA, the CDC and the ADA.

Patient Information

Name_____

Height _____ Weight _____

Gender: ___Female ___Male

Emergency Contact _____ Phone # _____ Relation _____

Nearest Relative Not Living With You_____Relationship_____

Phone (___) _____

Primary Physician _____Phone #_____

Please list any medications you are currently taking:

_____

_____

Insurance Information

Primary Dental Carrier:

Subscriber _____ Social Security # _____ DOB _____

Employer _____Insurance Company _____

Insurance Company Phone # _____Group # _____

Subscriber's Relation to Patient _____

Insurance Authorization

I hereby authorize payment directly to the dental office 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 _____

Guardian Signature _____ Date_____

Relation to Patient _____

Patient Agreement

At Wellness Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation.

We work with thousands of insurance companies. Although we can maintain computerized histories of payment by a given company, fees do change regularly; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. As a courtesy, we bill your insurance for you. We are a 'fee for service' establishment, so payment will be due at the time of treatment.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Signature_____Date_____

Guardian Signature_____ Date_____

Dental History

How did you hear about us? _____

If referred, who may we thank for your referral? _____

What is the reason for today's visit? _____

What would you like to change about your smile? _____

Why did you leave your last dentist? _____

When was your last dental visit? _____

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

Do your gums bleed while brushing or flossing? _____

Do you grind your teeth? _____

Do you snore or does your significant other snore? _____

Have you ever had prolonged bleeding after an extraction or surgery? _____

Are you currently having dental problems? _____

What are your dental concerns? *Check as many as are applicable:*

___Pain avoidance

___Appearance

___Losing teeth

___Gums/Periodontal Disease

___Cavities

___Oral Cancer

___Wasting/Exceeding Dental Insurance Limits

___Your general health

___Routine check up

___Cleaning

Other _____

Please note if you are interested in any of the following:

___More Attractive Smile

___ Implants

___ Bad Breath Treatment

___ Replacing Missing Teeth

___ Preventing Cavities

___ Veneers

___ Fixing Chipped Teeth

Treatment Authorization

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

I also understand that payment for all treatment and services rendered is my responsibility.

Patient's Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

Wellness Dental

Statement of office protocol

FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, VISA/MC/Discover and Automatic Credit Card Authorizations, as well as in house financing.

If you have insurance benefits we ask that you pay the deductible and the estimated co-payment at the time of service. We will submit the insurance claims as a courtesy to you; however, your insurance contract is between you and your insurance company. All patients are financially responsible for their accounts. The insurance company is responsible to the patient. We want to emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.

All charges you incur are your responsibility regardless of your insurance benefits. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however enter into a dispute with your insurance company over any claim. If problems arise in getting a claim paid, specific questions should be directed to your insurance carrier or employer.

Insurance payments are ordinarily received within 20-60 days from time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected. If payment is not received within 60 days from the date of filing, or your claim is denied, you will be responsible for paying the full amount at that time. If we receive any payments from your insurance company after you have paid in full, we will remit the payments directly to you.

APPOINTMENT POLICY

We respect the importance of your time and we work very hard to schedule appointments that accommodate the scheduling needs of all of our patients. We want you to know that we make every effort to see you at your scheduled appointment time. Unlike other dental practices, we do not double book appointments; in fact we allow a generous amount of time for both appointments and procedures. We feel that a successful outcome to treatment is the result of combined efforts of both you and this office. Therefore, it is important to adhere to the recommended treatment schedule to obtain optimum results. If you must cancel or reschedule an appointment, we require that you notify us at least 24 hours prior to your scheduled appointment time. Broken, missed, as well as late arrivals create scheduling problems for other patients as well as the practice. Appointments are considered reservations and you will receive a reminder call prior to this appointment. If we are unable to reach you, we trust that you will keep your reserved appointment. Repeated late cancellations or rescheduling will force us to double book your appointment or to institute a fee for missed appointments. We ask for your careful consideration regarding this matter. In return, we promise to provide you with the very best dental care.

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS REGARDING THE FINANCIAL AND APPOINTMENT POLICY FOR THIS PRACTICE. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

Patient Name **Signature of Guarantor, if Minor** **Date**