TRU SMILE NOW!

PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. First Name_____ M.I._____ Last Name_____
Sex ☐ Male ☐ Female Birth Date_____ Age_____ S.S. #_____ E-mail_____
Street_____ Apt_____ City_____ State_____ Zip_____
Tel. (_____)_____ Cell. (_____)_____ Have you ever been a patient of our practice? ☐ Yes ☐ No
Referred By_____ Has a family member ever been a patient of our practice? ☐ Yes ☐ No
Dentist_____ Orthodontist_____ Medical Dr._____
Driver's Lic #_____ Nearest relative not living with you_____ Tel. (_____)_____
Employer_____ Tel. (_____)_____ Personal Payment Type ☐ Cash ☐ Check ☐ Credit Card
In case of emergency, please contact_____ Tel. (_____)_____ Relation_____

WHO WILL BE RESPONSIBLE FOR YOUR ACCOUNT

Self (if self, skip this section) ☐ Spouse ☐ Father ☐ Mother ☐ Other
Name_____ Birth Date_____ Age_____ S.S. #_____
Tel. (_____)_____ Cell. (_____)_____ E-mail_____
Street_____ Apt_____ City_____ State_____ Zip_____
Driver's Lic #_____ Employer_____ Tel. (_____)_____

SPOUSE OR OTHER GUARANTOR INFORMATION (IF DIFFERENT FROM ABOVE)

Name_____ Relation_____ Birth Date_____ Age_____ S.S. #_____
Tel. (_____)_____ Cell. (_____)_____ E-mail_____
Street_____ Apt_____ City_____ State_____ Zip_____
Driver's Lic #_____ Employer_____ Tel. (_____)_____

INSURANCE INFORMATION

Student ☐ Full Time ☐ Part Time ☐ Not School Name Address
Marital Status ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated City State Zip
Employed ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Do you belong to a PPO or HMO ☐ Yes ☐ No

PRIMARY DENTAL INSURANCE COMPANY

Employer_____
Address_____
Tel. (_____)_____
Insurance Company Name I.D#_____
Address_____
Tel. (_____)_____ Group Name_____
Group_____ Insured Party_____
Relation_____ Birth Date_____
Sex ☐ M ☐ F
S.S. #_____ Tel. (_____)_____
Address_____

PRIMARY MEDICAL INSURANCE COMPANY

Employer_____
Address_____
Tel. (_____)_____
Insurance Company Name I.D#_____
Address_____
Tel. (_____)_____ Group Name_____
Group_____ Insured Party_____
Relation_____ Birth Date_____
Sex ☐ M ☐ F
S.S. #_____ Tel. (_____)_____
Address_____

SECONDARY DENTAL INSURANCE COMPANY

Employer_____
Address_____
Tel. (_____)_____
Insurance Company Name I.D#_____
Address_____
Tel. (_____)_____ Group Name_____
Group_____ Insured Party_____
Relation_____ Birth Date_____
Sex ☐ M ☐ F
S.S. #_____ Tel. (_____)_____
Address_____

SECONDARY MEDICAL INSURANCE COMPANY

Employer_____
Address_____
Tel. (_____)_____
Insurance Company Name I.D#_____
Address_____
Tel. (_____)_____ Group Name_____
Group_____ Insured Party_____
Relation_____ Birth Date_____
Sex ☐ M ☐ F
S.S. #_____ Tel. (_____)_____
Address_____

HEALTH HISTORY

To our patients: Although oral surgeons primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the care that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Reason for today's office visit?_____

1. Height_____Weight_____ Are you in good health? ☐ Yes ☐ No
2. Have there been any changes in your general health in the past year? ☐ Yes ☐ No
3. Are you under the care of a physician? Date of last visit ☐ Yes ☐ No
   If so, for what are you being treated?
4. Have you had any illness, operation or been hospitalized in the past five years? ☐ Yes ☐ No
   If so, describe
5. Do you have unhealed/ recurrent injuries or inflamed areas, growths or sore spots in or around your mouth?. ☐ Yes ☐ No
   If so, describe
6. Do you have a prosthetic joint/ implant? ☐ Yes ☐ No
   If so, describe where
7. Have you had a heart valve replacement or vascular graft? ☐ Yes ☐ No
8. Have you, or a family member, had any unusual or serious reactions to general anesthesia? ☐ Yes ☐ No
9. Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ Yes ☐ No

	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE	YES	NO	NOTES
1	Rheumatic fever?			
2	Damaged heart valves/ mitral valve prolapse			
3	Heart murmur?			
4	High blood pressure?			
5	Low blood pressure?			
6	Heart attack(s)?			
7	Chest pain/angina?			
8	Irregular heart beat?			
9	Cardiac pacemaker?			
10	Heart surgery?			
11	Pneumonia, bronchitis, chronic cough?			
12	Asthma?			
13	Hay fever/sinus problems?			
14	Snoring/sleep apnea?			
15	Difficult breathing/other lung trouble?			
16	Tuberculosis?			
17	Emphysema?			
18	Do you smoke? If so, number of packs a day _____			
19	Do you use chewing tobacco?			
20	Blood tranfusion?			
21	Blood disorder such as anemia?			
22	Bruise easily?			
23	Bleeding tendecy/ abnormal bleeding?			
24	Hepatitis, jaundice, or liver disease?			
25	Infectious mononucleosis?			
26	Gallbladder trouble?			

	HAVE YOU HAD, OR DO YOU CURRENTLY HAVE	YES	NO	NOTES
27	Fainting spells?			
28	Convulsions/epilepsy?			
29	Stroke?			
30	Thyroid trouble?			
31	Diabetes?			
32	Low blood sugar?			
33	Kidney trouble?			
34	High cholesterol?			
35	Are you on dialysis?			
36	Swollen ankles/arthritis/ joint disease?			
37	Osteoporosis/osteoperia?			
38	Osteonecrosis?			
39	Stomach ulcers/acid reflux?			
40	Contagious disease?			
41	Sexually transmitted diseases?			
42	Problems with immune system? Possibly from medication/surgery, etc.			
43	Delay in healing?			
44	A tumor or growth?			
45	Cancer/radiation therapy/ chemotherapy?			
46	Are you on a diet?			
47	A history of alcohol abuse?			
48	Contact lenses?			
49	Eye disease/glaucoma?			
50	Mental health problems/ anxiety/depression?			
51	A removable dental appliance?			
52	Pain or clicking of jaws when eating?			

WOMEN ONLY (QUESTIONS 53-54)

53. Is there a possibility of pregnancy? ☐ Yes ☐ No
54. Expected delivery date? ☐ Yes ☐ No
55. Are you nursing? ☐ Yes ☐ No
56. Are you taking birth control pills? ☐ Yes ☐ No

Note: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician I gynecologist for assistance regarding other methods of birth control.

	ARE YOU NOW TAKING?	YES	NO	NOTES
57	Any kind of medication, drug, pills?			
58	Blood thinners (Coumadin, Plavix, Aspirin, Vitamin E, Ginkgo Biloba, Aggrenox, Pradaxa, fish oil)?			
59	Have you ever taken diet pills?			
60	Any natural product, herbal supplement or homeopathic remedy?			
61	Are you taking, or have you ever taken bone density meds, or bisphosphonates such as Fosamax, Boniva, Actonel, IV-Zometa, Aredia, or Reclast in the past 12 years?			
62	Tranquilizers, sleeping pills, anti-depressants, and/or narcotics on a regular basis? If so, please list: _____ _____			
63	Please list any medications you are currently taking: Medication/Dosage/Frequency _____ _____ _____			

	ARE YOU ALLERGIC TO, OR HAD A REACTION TO	YES	NO	NOTES
64	Local anesthetic (numbing meds)?			
65	Penicillin?			
66	Other antibiotics?			
67	Sulfa drugs?			
68	Sodium pentothal/vadium/ other tranquilizers?			
69	Aspirin?			
70	Amoxicillin?			
71	Codeine or other narcotics?			
71	Other medications?			
70	Latex?			
71	Soy?			
72	Eggs yolks?			
73	Sulfites?			
74	Do you have any known allergies?			
75	Please list any allergies other than drug allergies: _____ _____			
76	Is there any family history of: ☐ Cancer ☐ Diabetes ☐ Heart disease ☐ Anesthesia problems			

77. If you are having surgery today, have you had anything to eat or drink in the last 6 (six) hours? ☐ Yes ☐ No
78. Who is driving you home?_____
79. Is there any condition concerning your health that the Doctor should be told about? ☐ Yes ☐ No
    If Yes, describe_____
80. Do you wish to speak to the Dr. privately about anything ☐ Yes ☐ No
81. Is this visit related to an accident? ☐ Yes ☐ No
    If Yes, what type of accident? ☐ Automobile ☐ Work related ☐ Other
    Date of injury_____Insurance company handling the claim_____
    Claim number_____Name of attorney / adjustor_____Telephone number (_____)_____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his / her staff, responsible for any errors or omissions that I have made in the completion of this form.

Signature of patient (Parent or Guardian if Minor) | **Reviewed by** | **Date**

FEES & PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorneys fees, and court costs.

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

AUTHORIZATION

I authorize my surgeon and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x-rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any infor· mation acquired in the course of my examination and treatment to

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

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Financial & Appointment Policy

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 needed to enjoy a healthy & confident smile with respect to your budget.

DENTAL INSURANCE

We are happy to file the forms necessary to see that you receive the full benefits of your coverage; however, we can make no guarantee of any estimated coverage. Please note that your dental policy is an agreement between you and the insurance company' and we ask that all patients be directly responsible for all charges. If you have any questions or discrepancies regarding your billing statement once you receive it, please contact us immediately. Otherwise, finance charges will incur 30 days after your last treatment, and the interest will be calculated at 1.5% per month (18.5% annually).

PAYMENT OPTIONS

Payment of patient portions may be made with the following:

- Cash, Check or Money Order.
- Major Credit/Debit Card (Such as Visa, Master Card, American Express, Etc.)
- Third Party Financing (Such as Care Credit or Loan Hero)
- In Office Payment Plan. For patients who desire a monthly payment plan, we can make arrangements with you & customize a payment plan.

Statements are mailed to all accounts monthly and are due upon receipt.

Due to the extensive amount of time our team and doctors devote to preparing and reserving time for visits, we require payments to be set up or payment to be made at the time of scheduling. If for any reason you cancel the reserved time with or without notice you will be subject to bank, financial and administration fees.

APPOINTMENT EXPECTATIONS & CANCELATION POLICY:

We work very hard at treating our patients as unique individuals. We try to remain responsive to each person's needs. Unlike many dental practices where the dentist sees multiple patients at one time, we try to schedule one patient at a time.

Short notice cancellations or missed appointments increase our cost of providing dental care costs that ultimately must be passed onto you, our patient. More importantly, missed appointments do not allow us the opportunity to offer the appointment to other patients seeking our care. For these reasons, we ask that you read and agree to the expectations:

- Please respect our time & that of other patients by giving us a minimum of two business days' notice to cancel an appointment Patients with appointments which are missed or cancelled with less than 48 hours' notice may incur a charge of $100.00 per appointment hour.
- Reminder calls placed by the office are a courtesy and do not affect the cancelation policy. IE if a patient does not receive a reminder call at all or less than 48 hours prior to appointment and they cancel a charge will still be incurred.
- $50 fee applies to retrieval or transfer of records.

I agree that I have read this information and fully understand the financial & appointment policies for Wellness Dental. I authorize this office to release any necessary information to expedite insurance claims. I understand that I am solely responsible for all charges, regardless of insurance coverage. I agree to pay any collection fees or attorney expenses should it be necessary to refer this account to collections and understand that any unpaid accounts will be reported to the credit bureaus.

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

_____ _____

Signature of patient (Parent or Guardian if Minor) **Date**

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CONSENT TO DENTAL PHOTOGRAPHY

I,_____, authorize Wellness Dental, to take photographs, and/or videos of my face, jaws and teeth, before, during and after treatment.
I consent to allow the photographs to be used for the following:

- Dental Records
- Training Purposes
- Dental Research
- Before and After Photos
- Dental Education including lectures, seminars, demonstrations, professional publications such as journals or books
- Marketing material, including websites and printed materials, patient education

I further understand that if the photographs and/or videos are used, my name or other identifying information will be kept confidential.
I do not expect compensation, financial or otherwise, for the use of these photographs.

☐ Check here if you do not want your full face shot or video used for any of the above purpose

Signature (Patient)_____

Date _____