Waldorf Cosmetic and Implant Dentistry

Patient Information

Name: ☐Mr. ☐Mrs. ☐Ms. ☐Dr. _____ MI_____ Male ☐ Female☐
☐Single ☐Married Birthdate:_____ Social Security #:_____

Home address: _____ City:_____ State: _____ Zip:_____
Home phone: _____ Mobile phone:_____ Email:_____
Work phone:_____
Employer: _____ Business phone:_____
Business address: _____ City: _____ State: ____ Zip:_____

Whom may we thank for referring you to our office? _____
Where do you prefer to be contacted? ☐ Home ☐Cellular ☐Business ☐Email

DENTAL INSURANCE INFORMATION

Name of insured person: _____ MI_____ Relationship to patient: _____
Employer:_____ Business phone:_____
SS#:_____ ID#: _____ DOB:_____
Insurance Co. name: _____ Phone: _____ Group #:_____

ADDITIONAL DENTAL INSURANCE INFORMATION

Name of insured person: _____ Relationship to patient:_____
Employer: _____ Business phone:_____
Business address: _____ City: _____ State: ____ Zip: _____
Insurance Co. name: _____ Phone: _____ Group #:_____

RESPONSIBLE PARTY

Name of person responsible for payment:_____ Relationship to patient:_____

If the person responsible for payment is someone other than the patient, please complete the section below so that we have the appropriate billing information for your account.

Is the person responsible for payment currently a patient in our office? Yes ❑No ❑

Home address:_____ City: _____ State:____ Zip:_____
Home phone: _____ Mobile phone:_____ Email:_____

Employer: _____ Business phone:_____
Business address: _____ City:_____ State: ____ Zip: _____

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Health History

Patient name:_____ Birthdate:_____
Physician name: _____ Physician phone: _____

Do you take any medications?
Yes ❑No ❑If yes, please list all medications and the reason why you are taking them.

_____

_____

Do you smoke cigarettes or use smokeless tobacco? Yes ❑ No ❑
Have you ever taken oral or intravenous bisphosphonate drugs for osteoporosis, metastatic cancer, or other conditions? Examples of bisphosphonates are alendronate (Fosamax®), risedronate (Actonel®), pamidronate (Aredia®) and zoledronate (Zometa®).
Yes ❑No ❑

Are you allergic to any of the following?

Yes	No		Yes	No		Yes	No	
❑	❑	Penicillin	❑	❑	Sulfa Drugs	❑	❑	Other Allergies (if yes, explain)
❑	❑	Local anesthetics	❑	❑	Latex			_____

Do you have, or have you ever had, any of the following?

Yes	No		Yes	No	
❑	❑	Alcohol or drug addiction	❑	❑	High Blood Pressure
❑	❑	Anemia	❑	❑	HIV or AIDS
❑	❑	Artificial joint replacement (hip, knee, etc.)	❑	❑	Kidney problems
❑	❑	Artificial heart valve	❑	❑	Liver problems
❑	❑	Asthma	❑	❑	Lung problems
❑	❑	Cancer	❑	❑	Psychiatric care
❑	❑	Congenital heart defect	❑	❑	Respiratory problems
❑	❑	Corticosteroid treatment	❑	❑	Radiation treatment
❑	❑	Dental phobia or anxiety	❑	❑	Rheumatic fever
❑	❑	Diabetes	❑	❑	Sinus problems
❑	❑	Epilepsy or seizures	❑	❑	Stomach or intestinal problems
❑	❑	Excessive bleeding	❑	❑	Stroke
❑	❑	Fainting spells or dizziness	❑	❑	Thyroid problems
❑	❑	Heart murmur	❑	❑	Tuberculosis
❑	❑	Sickle Cell	❑	❑	Tumors or growths
❑	❑	Heart attack or heart problems/pacemaker	❑	❑	Other health problems
❑	❑	Hepatitis	❑	❑	If female, are you pregnant?
❑	❑	Herpes or cold sores	❑	❑	If female, do you take birth control pills?

Please provide additional information for all "yes" responses:

_____

Signature:

_____ Date:_____

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Dental History

Patient name: _____

What is the reason for your dental visit today?_____

_____

_____

Do you currently have any teeth that are sensitive?
Yes ❑No ❑If yes, please explain._____

_____

When was the last time you saw a dentist? _____

When was your last professional cleaning?_____

How often do you brush your teeth? _____

How often do you floss your teeth?_____

	Yes	No
Have you ever been treated for periodontal disease (gum disease)?	☐	☐
Do you feel that you can chew well with your teeth?	☐	☐
Do you grind or clench your teeth?	☐	☐
Do you ever have jaw pain or jaw muscle soreness?	☐	☐
Have you ever worn a nightguard or been told that you should?	☐	☐
Do you like the way your smile looks?	☐	☐
Do you like the color of your teeth?	☐	☐
Do you have any teeth or restorations that you are unhappy with?	☐	☐
Would you like to discuss esthetic improvements that can be made to your smile?	☐	☐

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FINANCIAL POLICY

We are committed to providing you with the best possible care and would be happy to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your financial responsibility.

If you do not have insurance, we expect payment in full for all treatment at the time of service unless other arrangements have been made through the office manager. We accept cash, checks, and all major credit cards, Carecredit and Citi Health Card.

CANCELLATION POLICY

Appointments are made with our patients consent. There will be a $50 charge for any appointments that are failed or changed in less than 48 hours. This fee must be paid prior to scheduling any further appointments.

REGARDING INSURANCE

If you have insurance, we will help you receive maximum benefits. Your insurance claim will **ONLY** be completed and submitted if we are provided with all pertinent insurance company information. It is **YOUR RESPONSIBILITY** to verify that your policy is in force on your date of service. Otherwise, you are responsible for payment at the time of service.

Insurance is an agreement between you and your insurance company. We file insurance claims as a courtesy to you, our patient. We will not become involved in disputes between you and your insurance company regarding deductibles, co-payments, covered charges, secondary insurances, "usual and customary" charges, etc., other than to supply necessary factual information. **Deductibles and co-payments are required at time of service. You are responsible for the payment of your account.** If payment is not received from your insurance company within 45 days, the balance on the account becomes your responsibility.

AGREEMENT

I have read the above Financial Policy and understand that I am financially responsible for all charges whether or not paid by my insurance. I understand and agree that my account may be turned over to a collection agency after 90 days and that a collection fee will be added to my account.

Patient Name:_____

Responsible Party Signature:_____Date:_____

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: **PATIENT GIVING CONSENT**

Name: _____ DOB: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—**PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.**

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time. Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

CONSENT I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

REVOCATION OF CONSENT: I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____