Welcome TO OUR PRACTICE

Thank you for trusting us with your dental care. We promise to do our best to provide you with the finest care available. If you have any questions please do not hesitate to call us.

Patient # _____

SS # _____

Date _____

PATIENT INFORMATION

Name _____ Birthdate _____ Phone (_____) _____

Address _____ City _____ State _____ Zip _____

Sex ☐ M ☐ F ☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

E-mail _____ Alt. Phone #1 (_____) _____ Alt. Phone #2 (_____) _____

Employer/School _____ Employer/School Phone (_____) _____

Employer/School Address _____ City _____ State _____ Zip _____

Spouse or Parent's Name _____ Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone (_____) _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account _____ Relation to Patient _____

Address _____ Home Phone (_____) _____

Driver's License # _____ Birthdate _____ Bank _____

Employer _____ Work Phone (_____) _____

Currently a patient in our office? ☐ Yes ☐ No E-mail _____ Cell Phone (_____) _____

INSURANCE INFORMATION

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

ADDITIONAL INSURANCE

Name of Insured _____ Relation to Patient _____

Birthdate _____ Social Security # _____ Date Employed _____

Employer _____ Work Phone (_____) _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Union or Local # _____

Address _____ City _____ State _____ Zip _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

– OVER –

DENTAL HISTORY

Reason for today's visit _____ Date of last dental care _____

Former Dentist _____ Date of last dental X-rays _____

Address _____

Check (✓) if you have had problems with any of the following:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaw
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold
- ☐ Sensitivity to hot
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

MEDICAL HISTORY

Physician's Name _____ Date of last visit _____

Have you ever used a bisphosphonate medication? Common brand names are Fosamax, Actonel, Atelvia, Didronel, Boniva. ☐ Yes ☐ No

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Congenital Heart Lesions	☐	☐	Hepatitis	☐	☐	Scarlet Fever
☐	☐	Arthritis, Rheumatism	☐	☐	Cortisone Treatments	☐	☐	Hernia Repair	☐	☐	Shortness of Breath
☐	☐	Artificial Heart Valves	☐	☐	Cough, Persistent	☐	☐	High Blood Pressure	☐	☐	Skin Rash
☐	☐	Artificial Joints, Pins, etc.	☐	☐	Cough up Blood	☐	☐	HIV/AIDS	☐	☐	Stroke
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Jaw Pain	☐	☐	Swelling of Feet or Ankles
☐	☐	Back Problems	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Thyroid Problems
☐	☐	Bleeding Abnormally	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Tobacco Habit
☐	☐	Blood Disease	☐	☐	Glaucoma	☐	☐	Mitral Valve Prolapse	☐	☐	Tonsillitis
☐	☐	Cancer	☐	☐	Headaches	☐	☐	Pacemaker	☐	☐	Tuberculosis
☐	☐	Chemical Dependency	☐	☐	Heart Murmur	☐	☐	Radiation Treatment	☐	☐	Ulcer
☐	☐	Chemotherapy	☐	☐	Heart Problems	☐	☐	Respiratory Disease	☐	☐	Venereal Disease
☐	☐	Circulatory Problems	☐	☐	Hemophilia	☐	☐	Rheumatic Fever			

List medications you are currently taking and the correlating diagnosis:

_____

_____

_____

Allergies:

_____

_____

_____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies)

Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year from the date signed below.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

Payment is due in full at time of treatment unless prior arrangements have been approved.

WOODRIDGE
FAMILY DENTAL

DENTAL TREATMENT CONSENT FORM

Name:_____ **Date of Birth:** _____

1. WORK TO BE DONE

I understand that I am having the following work done: Fillings____ Bridges____ Crown____ Extractions____ Impacted teeth removed____ General Anesthesia____ Root Canals_____

Initials_____

2. DRUGS AND MEDICATION

I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction)

Initials_____

3. CHANGES IN TREATMENT PLAN

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

Initials_____

4. REMOVAL OF TEETH

Alternatives to removal have been explained to me(root canal therapy, crowns, and periodontal surgery, etc) and I authorize the Dentist to remove the following teeth _____and any others necessary for reasons in paragraph #3. I understand removing teeth does not always remove the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss f feeling in teeth, lips, tongue, and surrounding tissue that can last for an indefinite period of time(days or months) or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

Initials_____

5. CROWNS, BRIDGES, AND CAPS

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown or bridge(including size, shape, fit, and color) will be before cementation.

Initials_____

6. DENTURES, COMPLETE OR PARTIAL

I understand that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in new dentures (including shape, fit, size, placement, and color) will be the "teeth in max" try in visit. I understand that most dentures requite approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

Initials_____

7. ENDODONTIC TREATMENT (ROOT CANAL)

I realize there is no guarantee that root canal treatment will save my tooth. and that complications can occur from the treatment and that occasionally metal object are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally addition surgical procedures may be necessary following root canal therapy (apicoectomy)

Initials_____

8. PERIODONTAL LOSS (TISSUE & BONE)

I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition.

Initials_____

I understand that Dentistry is not an exact science and that, therefore, reputable practioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for myself or my minor child. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

_____ _____

Signature of patient, parent, guardian, or personal representative Date

_____ _____

Please PRINT name of patient, parent, guardian, or personal representative Relationship to Patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand that you are not required to agree to my requested restriction, but if you agree then you are bound to abide by such restrictions.

Patient Name (print) _____

Relationship to Patient _____

Signature _____ Date _____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

Patient Name _____ Date of Birth _____

Address _____

If the address provided above is not your home address or it is not a stress address, please provide us with a street for purposes of ensuring payment. *written communications

Home # _____ may we leave a message? Yes _____ No _____
Work # _____ may we leave a message? Yes _____ No _____
Cell # _____ may we leave a message? Yes _____ No _____
Email _____ may we send an email? Yes _____ No _____

May we send an appointment reminder text message? Yes _____ No _____
May we leave a message that you need pre-medication? Yes _____ No _____
May we leave a message that you have a dental appointment? Yes _____ No _____
I do not want a reminder left at all _____ (initials)
I do not want a postcard sent _____ (initials)

I understand that the office may charge me should I fail to keep my appointment * oral communications

FOR OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on the *Notice of Privacy Practices* but was unable to do so as documented below.

Date _____ Reason _____ Initials _____

OFFICE POLICIES

Please take time to read and understand your insurance policy and benefits. Our goal is to help you achieve and maintain optimal dental care.

Cancellation Policy:

Broken dental appointments are a disappointment to everyone, interfere with your dental treatment, and create unnecessary scheduling problems for other patients.

Scheduled appointments are reserved specifically for you, therefore, when sufficient notice is not given when you cancel or reschedule an appointment, it does not give us enough time to contact another patient on our waiting list who would benefit from coming in earlier. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may offer that time to another patient.

We understand that rare emergency situations may occur, and under those circumstances we can completely understand. However, **if two cancelled/missed appointments occur without 24 hour notice, our office reserves the right NOT to schedule any subsequent appointments**. Also, if you arrive late, you may be asked to reschedule for the next available appointment time. When 24 hour notice has not been given, a charge may be added to your account upon the discretion of our office.

Financial Policy:

Payments/Co-Payments for services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan for services with estimated costs so that you can be prepared for payment on your next visit. As a courtesy to our patients, we will file your dental insurance claims and bill your dental insurance company (if applies) for treatment you receive. However, in the event the insurance company does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

All Medicaid/All-Kids Insurance patients must bring in a current insurance card at every appointment. If it is not available, your appointment must be rescheduled to when the card is available. These missed appointments will be considered cancellations without 24 hr notice.

Parent / Legal Guardian must accompany a minor for initial exam, emergencies and recall visits.

_____ _____

Printed name of Patient, Parent or Guardian Date

_____ _____

Signature of Patient, Parent or Guardian Date