DENTISTRY AT

WINDERMERE

Name:_____

Preferred Name:_____ ☐Male ☐Female

Home Address: _____ City_____ State_____ Zip_____

Mailing Address: _____ City_____ State_____ Zip_____

DOB: _____ S.S._____ Email:_____

Marital Status:_____ Spouse Name:_____

Home #_____ Cell #_____ Work #_____ Ext_____

Occupation:_____ Employer:_____

Person Responsible for account

☐self (only check if all info is the same as above)

Name:_____ DOB:_____ S.S._____

Address: _____ City_____ State_____ Zip_____

Relationship to patient_____ Employer/Occupation_____

Home #_____ Cell #_____ Work #_____ Ext_____

Dental Insurance

☐ I do not currently have dental insurance

Subscriber's Name _____ Insurance Company_____

Relationship to Patient _____ Policy/Group Number_____

Subscriber's Employer _____ Address _____

Subscriber's SS# or ID#_____ City/St/Zip _____

Subscriber's Birth Date _____/_____/_____ Ins. Phone# (_____)_____

Emergency Contact

Name:_____ Relation:_____

Home #_____ Cell #_____ Work #_____ Ext_____

Help us get to know you

How did you hear about our office?

☐Sign ☐Mailer ☐Website ☐insurance ☐Yellow Pages

☐Other_____ ☐Family / Friend_____

Signature:_____ Date:_____

(Patient or Parent/Guardian)

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MEDICAL HISTORY

PATIENT NAME: _____DOB: _____

Although dental personnel 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 inter-relationship with the dental treatment you will receive.

Thank you for answering the following questions to help serve you better.

What would you rate your anxiety level for Dental Treatment? ☐ Low ☐Average ☐slightly above Average ☐High

Have you been told you need PRE-MEDICATED before dental treatment and/or cleaning? ☐YES ☐NO

Are you under a physician's care? ☐YES ☐NO If yes please explain_____

Have you ever been hospitalized or had major surgery? ☐YES ☐NO If yes please explain_____

Have you ever had a serious head or neck injury? ☐YES ☐NO If yes please explain_____

Do you, or have ever taken Phen-Fen or Redux? ☐YES ☐NO If yes please explain_____

Are you on a special Diet? ☐YES ☐NO If yes please explain_____

Do you use tobacco products? ☐YES ☐NO If yes how often_____

Do you use controlled substances? ☐YES ☐NO If yes please explain_____

ARE YOU TAKING ANY MEDICATIONS? ☐YES ☐NO If yes please explain_____

Women Only: Are you pregnant or trying to get pregnant? ☐YES ☐NO if yes how far along are you_____

Taking oral contraceptives? ☐YES ☐NO Nursing? ☐YES ☐NO

ALLERGIES: please check all that apply

☐Latex ☐Codeine ☐Acrylic ☐Sulfa ☐Aspirin ☐Penicillin ☐Metal ☐Local Anesthetics ☐Erythromycin

☐Other: _____

Do you or have you ever had any of the following: ***Please check all that apply***

☐Anemia	☐Epilepsy/Seizures	☐Hypoglycemia	☐Radiation/Chemo
☐Arthritis	☐Excessive Bleeding	☐Jaundice	☐Respiratory Problems
☐Artificial Joints	☐Fainting/Dizzy Spells	☐Kidney Disease	☐Rheumatic Fever
☐Asthma	☐Glaucoma	☐Liver Disease	☐Sinus/Hay Fever
☐Back Problems	☐Head/Neck Injuries	☐Low Blood Pressure	☐Stomach Problems
☐Blood Disease	☐Heart Attack/Failure	☐Migraine Headaches	☐Stroke
☐Cancer	☐Heart Murmur	☐Mitral Valve Prolapse	☐Thyroid Disease
☐Cold Sore/Fever Blister	☐ Hepatitis (☐A ☐B ☐C)	☐Nervous Disorder	☐TM J (jaw joint pain)
☐Depression	☐High Blood Pressure	☐Pacemaker	☐Tuberculosis
☐Diabetes	☐High Cholesterol	☐Physical Disability	☐Tumor or growth
☐Drug Addiction	☐HIV Positive	☐Psychiatric Problems	

☐Other:_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can Be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes & updates to my medical health status.

Signature: _____ Date:_____

(Patient or Parent/Guardian)

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Dental History

Welcome! We are so glad that you are here. Please complete this dental history form so that we may provide you with the best possible care. All information is kept confidential.

Date:_____ Name:_____

Reason for your visit today?_____

_____

_____

Approximate Date of:

Last Dental Exam: _____ Last Cleaning:_____ Full Set of X-rays: _____

Dental Anxiety Level: ☐Low ☐Normal ☐High

What kind tooth brush do you use? ☐Manual ☐Electric What type? ☐Soft ☐Medium

Do you use any other dental aids? (Check all that apply) ☐Water Pik ☐Toothpicks ☐Fluoride rinse

☐Mouth Wash ☐Other_____

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

Are any of your teeth sensitive to: (check all that apply) ☐Hot ☐ Cold ☐Sweets ☐Chewing /Pressure

Have you ever had *(check all that apply):*

☐ Orthodontic treatment/Braces
☐ Endodontic treatment/Root Canal
☐ Extractions/Oral Surgery
☐ Gum Surgery
☐ Bite Lips or Cheeks
☐ Scaling and root planning/Deep Cleaning
☐ Cold Soar/Fever Blister
☐ Frequent Canker Soars
☐ Smoke Tobacco
☐ Chew Tobacco
☐ Occlusal or Bite adjustment
☐ Teeth Whitening/Bleaching
☐ Clicking or Popping of the Jaw
☐ Pain in Ear, Jaw or Face
☐ Difficulty Opening or closing mouth
☐ frequent Headaches
☐ Excessive Stress

Check any that apply to you:

☐ Bleeding or Painful Gums
☐ Bad taste in your mouth
☐ Loose Teeth
☐ Wear Night guard
☐ Food Catching between your Teeth
☐ Clench/grind teeth

Signature:_____ Date:_____
(Patient or Parent/Guardian)

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used & disclosed & how you can get access to this information. Please review carefully. We respect our legal obligation by law to give you notice of our privacy policies. This notice describe to you how we protect your health information & what rights you have regarding it.

*The most common reasons why we use or disclose your health information is for treatment, payment or health care Operations, such as when making an appointment, referring you to another doctor, faxing prescriptions to be filled are examining your teeth, preparing & sending bills or insurance claims, collecting unpaid amounts ,financial audits, internal quality assurance, defense of legal matters, or business planning. Unless you object, we will also share relevant information about your care with your family/caregivers/guardian who are helping you with your dental care.

USES AND DISCLOSURES FOR OTHER REASONS WITHOUT PERMISSION: In some limited situations, the law allows or requires us to use or disclose your health information without your permission. Not all of these situations will apply to us. Such uses or disclosures are: When a state law mandates that certain health information be reported for a specific purpose. For public health purposes, such as infectious disease reporting. Disclosures to government authorities about victims of suspected abuse, neglect or domestic violence. Uses & disclosures for health oversight activities ,such as the licensing of doctors & audits by Medicare & Medicaid. Disclosures in response to subpoenas or court orders & for law enforcement purposes, such as a suspected victim of a crime. Disclosure to the medical examiner to identify a person or to determine a cause of death. For public related research. Uses & Disclosures to prevent a serious threat to health or safety. Disclosures to business associations who perform health care operations for us & who commit to respect the privacy of your health information.

APPOINTMENT REMINDERS: We may call or write to remind of scheduled appointments or that is time to make an appointment. Unless you tell us otherwise, we may mail you an appointment reminder postcard &/or leave you a reminder message on the phone you have provided us & are with the person who may answer the phone.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION: The law gives you many rights regarding your health information. You can choose to ask us to restrict our uses & disclosures for purposes of treatment (except in case of emergency treatment), payment are health care operations. We do not have to agree to this, but if we agree, we must honor the restrictions that you have requested. To request a restriction, you must send your request in writing. Ask us to communicate with you in a confidential way, such as phoning you at your work phone rather than your home phone or by using your email to your personal email address. Ask to see or get photocopies of your health information. By law, there are a few situations in which we can refuse to permit access or copying. For the most part, your will be able to get a copy of your health information within 30 days of asking us (60 is info is stored off site). You may have to pay a fee for copying in advance. To get photocopies, please submit a written request. Ask us to amend your health information if you believe it is incorrect/incomplete. Get a list of the disclosures that we have made of your health info with the past six years. By law, the list will not include: Disclosures required by law & some other limited disclosures. You are entitled to one such list per year at no charge. To request such a list, you must submit a written request. Get additional paper copies of this Notice of Privacy Practices upon request.

By law, we must abide by the terms of this Notice of Privacy Practices until we choose to change it. We reserve the right to change this notice at any time as allowed by law. If we change this Notice, the new privacy practices will apply to your health information already on file as well as to such information we may generate in the future. If we change our Privacy Practices, we will post it in the office & make copies available.

COMPLAINTS: If you think that we have not properly respected the privacy of your health information, you are free to complain to us of to the U.S. Dept. of Health & Human Services, the office for Civil Rights, We will not retaliate against you if you do choose to make a complaint.

ACKNOWLEDGEMENT OF RECEIPT: I acknowledge that I have rec'd a copy of the Privacy Practices.

Print: _____ **Date**: _____

Signature: _____

(Patient or Parent/Guardian)

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Financial Policy

We appreciate the value of your time and strive for on time appointments. Our goal is to give each patient the personal & individual attention you deserve for each & every appointment**.** We work by scheduled appointments and ask that you make every possible effort to be on time for the appointment we have reserved especially you. We ask that you give a **48 Hrs Notice if you find it necessary to cancel or reschedule** your appointment, **or a Broken appointment fee of $50 (per hour for Dr's time) may be assessed**.

First missed appointment: We will give you a verbal reminder of our office policies

Second missed appointment: Written Notice with a statement of the charge posted & billed to your account

Third missed appointment: Showing a lack of commitment for your dental health and our providers time, may lead to being ask by our office that you seek another dentist for your dental treatment.

Please be courteous & call as soon as possible, you may also leave a message on our night recorder

FINANCIAL OBLIGATIONS

Service is due/payable on the day services are rendered in our office, unless you have made prior arrangements with our office. As a courtesy, if you have dental insurance, we will accept the assignment of benefits and ask that you pay only the **estimated portion** on that day. **Be aware that the estimated amount is only an estimate (not a guarantee) by our office that is figured by information we have collected by phone/fax from your insurance. You will be fully responsible and billed for ANY REMAINING BALANCE after the insurance has paid benefits.** Should the insurance benefit check be sent to you, you will need to pay us immediately.

Please be aware that we will make every effort within our means to help you file for your benefits , but you are responsible for monitoring your dental insurance benefits and that the responsibility for your account balance is ultimately yours. **(Regardless of the insurance; we file your claims as a courtesy to you)** Should your account balance become 90-days PAST DUE, regardless of the insurance, the account balance will need to be Paid or may be turned over for collection; which you will then have additional fees added to your account for collection cost and any court cost and/or attorney fees.

I UNDERSTAND & AGREE: _____ _____

Signature(Patient/Parent or Guardian) Date

By signing, I authorize Dentistry At Windermere, PC to submit my claims electronically & assign benefits to be paid directly to this office. I understand that any claim or unpaid portion of a claim or claims is solely my responsibility & I agree to pay Dentistry At Windermere, PC in full for the services that have been rendered.

CLINICAL CONSENT

_____ I agree to update the medical history & personal information as required for myself & my dependents.

_____ I hereby authorize Dentistry At Windermere, PC to perform any necessary & mutually agreed upon x-rays, study models, Photographs (for diagnostics & identification purposes), or any other diagnostic aids deemed appropriate by the dentist for the sole purpose of proper diagnosis.

_____ Upon such diagnosis, I authorize Dentistry At Windermere, PC to perform any mutually agreed upon treatment, & to employ such assistance as required to provide proper care; including anesthetics, sedatives & others medications as necessary. I fully understand the use of anesthetics agents embodies certain risk. I understand that every precaution will be taken & that I may ask for a complete recital of any possible complications.

Signature: _____ Date: _____

(Patient or Parent/Guardian)