

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum

oral health. Please fill out this form completely. The better we communicate, the better we can care for you. ☺

1 ABOUT YOU

Today's Date: _____

E-mail Address: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____ Male Female

Birthdate: ___/___/___ Age: ___ SS #: _____

Home Address: _____
APT / CONDO #

CITY STATE ZIP

Single Married Divorced Widowed Separated

Hm #: (____) _____ Pager / Cell #: _____

Wk #: (____) _____ Ext: _____ DL #: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____) _____ Ext: _____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person Responsible for Account: _____

Contact #: (____) _____

Billing Address: _____

Relation: _____ SS #: _____

Employer: _____ DL #: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: (____) _____ Hm #: (____) _____

4 MEDICAL HISTORY

Do you have a personal physician? Yes No

Physician's Name: _____

Wk #: (____) _____ Date of last visit? _____

Are you under the care of a physician? Yes No

Please explain: _____

CONTINUED ON BACK

Dr. Barry Wilson

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement*

I, _____, have received a copy of this
office's Notice of Privacy Practices.

Please Print Name

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but
acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

Medical Information Release Form

(HIPAA Release Form)

Name: _____ Date of Birth ____/____/____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

Parent/Gaurdian _____ Phone # _____

Spouse _____ Phone # _____

Child(ren) _____ Phone # _____

Other _____ Phone # _____

Information is not to be released to anyone

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call my home _____ my work _____ my cell _____

If unable to reach me:

you may leave a detailed message

please leave a message asking me to return your call

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: _____

Witness: _____ Date: _____

FINANCIAL AND PATIENT POLICY FOR DENTAL CARE
Dr. Barry Wilson, DMD

GENERAL: Payment for dental care is due and payable at the time the care is rendered. Before care is rendered, we will discuss the need, possible treatment, alternatives and different costs involved. **If you have insurance, you must pay your deductible and your estimated portion at the time treatment is rendered.**

INSURANCE: Our office will file your Insurance. Patients are responsible for any unpaid balance not promptly paid by their insurance. We will do everything possible to help you obtain the entire insurance benefits to which you are entitled.

I understand that it is my responsibility to know: 1) The name of my insurance company 2) The amount of my deductible & yearly maximum 3) My benefits (what is covered & not covered) 4) If a prior authorization is required. _____ **Initial here**

To make your dental care more affordable, we offer Care Credit. It is a medical credit card that will allow you to make payments interest free for 6 or 12 months. You can apply at carecredit.com or our front desk staff can help you apply.

DELINQUENT ACCOUNT: Finance charges of 1.5% (18% APR) will be computed on all balances older than 60 days. The minimum finance charge to be applied to such accounts is \$1.50. In the event of default to pay, reasonable collection charges and/or attorney fees will be added to the account.

OTHER: There will be a \$20 charge on all returned checks.

CANCELLATIONS /APPOINTMENT NO-SHOWS: There will be a \$40/hour charge for a no show and appointments canceled without 24-hour notice. Please make the appointments that you schedule to keep the costs down for you and all patients.

PATIENT ACKNOWLEDGEMENT

I have read and understand this financial policy statement and I agree to its terms.

RESPONSIBLE PARTY

DATE

I HEREBY REQUEST THAT INSURANCE BENEFITS BE PAID TO THIS OFFICE AND AUTHORIZE THE RELEASE OF INFORMATION REGARDING INSURANCE CLAIMS PROCESSING.

PATIENT OR POLICYHOLDER

DATE

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MEDICAL HISTORY *continued*

Your current physical health is: Good Fair Poor

Are you taking any prescription / over-the-counter or supplemental drugs?

Yes No

Please list each one: _____

Do you smoke or use tobacco in any other form? Yes No

Have you ever taken Fosamax, or any other bisphosphonate? Yes No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? Yes No

For Women: Are you using a prescribed method of birth control? Yes No

Are you pregnant? Yes No Week #: _____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

- | | |
|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia / Radiation Treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia / Abnormal Bleeding |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial Bones / Joints / Valves | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis | <input type="checkbox"/> Y <input type="checkbox"/> N High / Low Blood Pressure |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N HIV+ / AIDS |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood Transfusion | <input type="checkbox"/> Y <input type="checkbox"/> N Hospitalized for Any Reason |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer / Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse |
| <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric Treatment |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Breathing | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic / Scarlet Fever |
| <input type="checkbox"/> Y <input type="checkbox"/> N Drug / Alcohol Abuse | <input type="checkbox"/> Y <input type="checkbox"/> N Severe / Frequent Headaches |
| <input type="checkbox"/> Y <input type="checkbox"/> N Emphysema / Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy/Seizures/Fainting Spells | <input type="checkbox"/> Y <input type="checkbox"/> N Sickle Cell Disease / Traits |
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever Blisters / Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Sinus Problems |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Attack / Stroke | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB) |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcers / Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Heart Surgery / Pacemaker | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal Disease |

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- | | | |
|--|--|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Aspirin | <input type="checkbox"/> Y <input type="checkbox"/> N Erythromycin | <input type="checkbox"/> Y <input type="checkbox"/> N Penicillin |
| <input type="checkbox"/> Y <input type="checkbox"/> N Codeine | <input type="checkbox"/> Y <input type="checkbox"/> N Jewelry / Metals | <input type="checkbox"/> Y <input type="checkbox"/> N Tetracycline |
| <input type="checkbox"/> Y <input type="checkbox"/> N Dental Anesthetics | <input type="checkbox"/> Y <input type="checkbox"/> N Latex | <input type="checkbox"/> Y <input type="checkbox"/> N Other |

Please list any other drugs / materials that you are allergic to: _____

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DENTAL HISTORY

Why have you come to the dentist today?

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

Have you ever had periodontal disease? Yes No

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? Hard Medium Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature _____

Date _____

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



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have questions at any time, please ask us. We are happy to help.

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

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____

1. Date: _____ Comments: _____ Signature: _____