WYNNEWOOD DENTAL ARTS

WELCOME

Date_____

PATIENT INFORMATION

Name_____ Preferred Name_____

Sex M F Date of Birth_____ Age_____ Social Security #: _____-_____-_____

Street Address_____ City/State/Zip_____

Mailing Address if different from above:_____

Home Phone_____ Cell Phone_____ Best number during the day_____

E-Mail Address_____ Single Married Widowed Separated Divorced

Employer (if child, parent information)_____ Occupation_____

Employer's Address_____Work Phone_____

Spouse's Name_____ Spouse's Occupation_____

Spouse's Birthdate_____ Spouse's Employer_____

Whom may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT (please specify someone who does not live in your household)

Name_____ Relationship_____

Home Phone_____ Work Phone_____

FINANCIAL INFORMATION

Who is responsible for this account?_____

Relationship to patient_____

Address (if different from above)_____

INSURANCE INFORMATION (if applicable)

Insurance Co Name_____ Ins Co Phone Number_____

Ins Co Address_____ Group #_____

Subscriber ID #_____ Subscriber's Social Security #_____

Subscriber's Name_____ Subscriber's Birthdate_____

Subscriber's Address (if different from above)_____

Relationship to patient_____

Please complete back page **Pt Initials:_____**

HEALTH HISTORY

Physician's Name________Date of last visit_____

Please circle any of the following that apply to you

A-Fib	Fainting or Dizziness	Psychiatric Care
Aids	Glaucoma	Radiation Treatment
Anemia	Headaches	Respiratory Problems
Acid Reflux	Heart Attack – When_____	Rheumatic Fever
Arthritis	Heart Murmur	Scarlet Fever
Artificial Heart Valves	Heart Problems	Shortness of Breath
Artificial Joints	Hepatitis Type_____	Shunts Placed _____
Asthma	Herpes	Sinus Trouble
Back Problems	High Blood Pressure	Skin Rash
Blood Disease	HIV Positive	Special Diet
Cancer	Jaundice	Stents Place_____
Chemical Dependency	Jaw Pain	Stroke
Chemo – When_____	Kidney Disease	Swelling of feet or ankles
Circulatory Problems	Liver Disease	Swollen Neck Glands
Congenital Heart Lesions	Low Blood Pressure	Thyroid Problems
Contact Lenses	Mitral Valve Prolapse	Tonsillitis
Cortisone Treatments	Nervous Problems	Tuberculosis
Cough	Pacemaker	Tumor on head or neck
Diabetes	Paresthesia	Ulcer
Emphysema	Women: Pregnant?	Venereal Disease
Epilepsy	Nursing?	Unexplained Weight Loss

MEDICATION

Please list any medications you are taking _____

_____

_____

Are you taking any Herbal medications?_____

Do you have difficulty getting numb?_____

IS PREMEDICATION NEEDED FOR YOUR DENTAL VISITS?_____

Allergies

Aspirin	Iodine	Penicillin	Seasonal
Barbiturates (sleeping pills)	Latex	Sulfa	Metal
Codeine	Local Anesthetic	Other (please list)_____	

Pt Initials:_____

DENTAL HISTORY

Reason for today's visit_____

Date of last dental visit_____

What services were performed at that time?_____

Date of last dental x-rays_____

Please circle any of the following that apply to you

Bad Breath	Food collection between teeth	Orthodontic Treatment
Bleeding Gums	Foreign Objects	Pain around ear
Blisters on mouth or lips	Grinding Teeth	Periodontal Treatment
Burning Sensation on tongue	Gums swollen or tender	Sensitivity to cold
Chew on one side of mouth	Jaw pain or tiredness	Sensitivity to hot
Cigarette, pipe, or cigar smoking	Lip or cheek biting	Sensitivity to sweets
Clicking or popping jaw	Loose teeth or broken fillings	Sensitivity when biting
Dry Mouth	Mouth Breathing	Sores or growths in mouth
Fingernail Biting	Mouth pain when brushing	

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

Do you use any mouth rinses (if yes then please list)_____

Anything you would like to address concerning the appearance of you teeth? _____

_____

Have you had a bad experience in a dental office in the past? If so what can we do to make you more comfortable?

_____

Are you interested in sedation options for your dental treatment? _____

Pt Initials:_____

PATIENT RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for the patient services provided by Wynnewood Dental Arts according to the policies stated in this Patient Responsibility Agreement.

The patient information provided to the dental office is true and correct. I will notify the dental office about any significant future revisions to the patient information furnished.

If I expect my insurer to cover some or all of the cost of the patient services, the dental office will assist me, as a courtesy, in obtaining the appropriate benefits from the insurer by billing the insurer. I agree to cooperate and provide all information necessary to the dental office. However, I have the primary relationship with my insurer and the dental office is not responsible for guaranteeing that benefits will be received in the amounts and in the time frame as requested. I am responsible to resolve any problems with my insurer. I may request that the dental office obtain a pre-estimate of insurance benefits before patient services are rendered.

Unless my treatment is scheduled over a period of time, and unless I specifically request, and the dental office approves, in advance, a payment schedule for the patient services, all payments for services are due at the time services are rendered. The dental office will not otherwise approve any deferred payment schedule.

It is possible that the insurer may not pay portions of the bill for patient services, such as co-payments, deductibles and exclusions. I must pay those unpaid portions when a billing statement is presented after the patient services are performed. Payments may be made in cash, check or by credit card. If my insurer has not paid the benefits to the dental office within 90 days after submitted, the dental office may then require me to pay for the patient services in full, and any insurance benefits later received by the dental office will be returned to me.

If my account is referred to an outside agency or attorney for collection after 90 days, I will also be responsible for actual collection costs incurred, including all attorney's fees and court costs. The dental office may deny subsequent patient treatment if my account balance remains unpaid.

If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1 ½% per month (18% annually). If an office appointment is cancelled with less than 24 hours notice, I can be assessed with a cancellation charge of $50. If my check is returned by the bank, I can be assessed with a processing charge of $35. I understand that where appropriate, credit bureau reports may be obtained.

Patient or Responsible Party Signature_____ Date_____

In an effort to provide you with flexible payment arrangements, we have expanded our payment policy.

PAYMENT ARRANGEMENTS ARE REQUESTED AT THE TIME OF YOUR VISIT.

We now offer the following payment options:

- Payment by cash
- Payment by check
- Payment by credit card (Amex, Discover, Visa, and MasterCard)
- Payment by Care Credit
- Automatic monthly billing to your credit card
- Guarantee any amount not covered by insurance with my credit card

Please make your choice, sign below and return to the office manager, Danielle, before treatment.

Our office is a fully approved and accredited user of the Visa and MasterCard Health Care Program which will enable you to use your card to automatically cover amounts not paid by your insurance. You may also choose a comfortable amount to be automatically billed to your credit card on a monthly basis.
If none of the above apply, please see the office manager. Thank you.

Sign X_____ Date:_____