Wellness Family Dentistry

Name ______________________ Birthday ____________ SS# ____________

Address ______________________ City/State ____________ Zip ________

Marital Status ________ Occupation ____________ Employer ______________

Home # ____________ Cell # ____________ Work # ______________

Dental INS Name ______________________ INS Carrier Name ______________________

ID# ______________ Carrier Birthday ____________ Carrier SS# ______________

Emergency Contact and Phone # ______________________ Relation ____________

Physicians Name and Phone # ______________________ Last Med. Exam ____________

Do you have any existing illnesses? If so please explain ______________________

Do you take any drugs or medications? Y N

Please list if yes ____

Have you been told to take antibiotics before any medical or dental treatment? Y N

Do you bleed excessively? Y N

Do you smoke or use tobacco? Y N

Do you take blood thinners? Y N

Are you pregnant? Y N

Do you now have or have you ever had any of the following:

Heart Disease	Y N	Kidney Disease	Y N	Diabetes	Y N
Blood Disease	Y N	Liver Disease	Y N	Epilepsy	Y N
Hepatitis	Y N	Asthma	Y N	Stroke	Y N
High Blood Pressure	Y N	Low Blood Pressure	Y N	HIV/Aids	Y N

Are you allergic to any listed below:

Latex Y N

Antibiotics Y N

Local Anesthetics Y N

Other ______________ How did you hear about us? ______________________

How often do you brush? ________ Floss? ________ Name of previous dentist ______________

Have you ever had periodontal treatment? ______ If so when? ________ Do you grind or clinch? Y N

When was your last dental visit? ____________ X-rays? ________ Cleaning? ____________

In signing this I agree to the best of my knowledge all information provided is true and accurate. I consent to whatever dental procedures and anesthetics are necessary.

Patient/Guardian Signature ______________________________ Date ____________

HIPPA PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient's consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment for health care operation, in order to provide health care that is in your best interests.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part your PHI. You may not revoke actions that have already been taken which relied on this or previously signed consent.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Please list family members that we are allowed to speak with regarding your care.

Name: ______________________________ Phone#: ________________
Name: ______________________________ Phone#: ________________
Name: ______________________________ Phone#: ________________

Patient Name: ______________________________

Signature: __________________________________ Date: ____________

WELLNESS FAMILY DENTISTRY

Notice to Patients of Wellness Family Dentistry Regarding Insurance Claims and Self Payment:

It is the PATIENT'S responsibility to know and understand the percentage and amount paid by their insurance company for dental services rendered by our office.

Insurance companies differ in methods of payment for dental services. For instance, sometimes they only pay for amalgam (silver) fillings, whereas our office only places composites (white) fillings. In such cases, the difference in price is the PATIENT'S responsibility even when he/she has 100% coverage.

As a courtesy to the patient, our office will file most insurance claims in order for the patient to receive the maximum possible coverage that is allowable by his/her insurance policy. However, any fees not covered by the insurance are ultimately due in full to our office from the patient.

* Our office is responsible for providing the patient with excellent dental care.
* Your dental "coverage" is between you and your insurance company.
* Your dental "fees" are between you and this dental office.

OVERALL, it is the PATIENT'S RESPONSIBILITY to make sure all fees are paid in full to Wellness Family Dentistry for services rendered.

We will attempt to reach out to the PATIENT for payments, but after a certain amount of time, if account balance is not paid, the unpaid fees will be sought by our collection agency.

In order for our office to continue to provide quality dental care to the community, all fees must be paid. Thank you for your understanding.

I, the undersigned understand and accept the policy explained above.

Patient Signature ______________________________ Date ____________