WOODLAKE
FAMILY DENTAL

Welcome!

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form to the best of your knowledge, if you have any questions we will be glad to help. We look forward to helping you in maintaining your dental health.

Patient Information

Patient Name:_____ DOB: _____

Sex: Male / Female SSN: _____ Status: Single __Married__ Widowed __ Other__

Address: _____City: _____ State:___ Zip:_____

Home #:_____ Cell #:_____ Email: _____

Emergency Contact Name: _____ Cell #:_____

Who may we thank for referring you?: _____

Primary Dental Insurance

Policy Holder:_____ DOB: _____

Relationship to patient: _____ SSN:_____ Home #_____

Address (if different from patient): _____

Policy Holder Employer: _____ Occupation: _____

Insurance Co: _____ Insurance #: _____

Group #:_____ Subscriber ID#_____

Additional Dental Insurance

Is this patient covered by additional dental insurance? If yes, fill out below.

Policy Holder:_____ DOB: _____

Relationship to patient: _____ SSN:_____ Home #_____

Policy Holder Employer: _____ Occupation: _____

Insurance Co: _____ Insurance #: _____

Group #:_____ Subscriber ID#_____

Dental History

What would you like us to do today? _____

Are you in any dental discomfort? _____

Former Dentist: _____ Phone #_____

Date of last dental visit: _____ Date of last x-rays: _____

How often do you brush?: _____ Floss?: _____

How do you feel about the overall appearance of your teeth?: _____

Circle Y/N whether you have had any of the following

Y/N Bad breath
Y/N Periodontal treatments
Y/N Sensitivity to sweets
Y/N Bleeding gums
Y/N Grinding or clenching
Y/N Sensitivity to hot / cold
Y/N Sensitivity on biting
Y/N Clicking or popping jaw
Y/N Broken fillings / Loose teeth
Y/N Sores or growths in mouth
Y/N Food collection between teeth

Medical History

Are you currently under physician care? Y/N If yes , describe: _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y/ N If yes, describe: _____

Have you ever been required to take antibiotics before a dental appointment? Y/N

Have you ever had a blood transfusion? Y/N If yes, give approx dates: _____

Women: Are you pregnant?: Y/N Nursing?: Y/N Taking birth control medication? Y/N

Circle Y/N whether you have had any of the following:

Y/N AIDS/HIV
Y/N Anaphylaxis reaction
Y/N Anemia
Y/N Anxiety
Y/N Arthritis, rheumatism
Y/N Artificial heart valves
Y/N Artificial joints
Y/N Asthma
Y/N Back problems
Y/N Blood disease
Y/N Cancer
Y/N Chemotherapy
Y/N Chronic headaches
Y/N Circulatory problems
Y/N Cortisone treatments
Y/N Depression
Y/N Diabetes I / II
Y/N Epilepsy
Y/N Food allergies
Y/N Genetic disorder
Y/N Glaucoma
Y/N Heart murmur
Y/N Heart problems
Y/N Heart surgery
Y/N Hemophilia / abnormal bleeding
Y/N Herpes
Y/N Hepatitis
Y/N High blood pressure
Y/N Kidney disease malfunction
Y/N Liver disease
Y/N Material allergies (latex, metals, etc.)
Y/N Mitral valve prolapse
Y/N Nervous problems
Y/N Pacemaker
Y/N Psychiatric care
Y/N Radiation treatment
Y/N Respiratory disease
Y/N Rheumatic fever
Y/N Shortness of breath
Y/N Spina bifida
Y/N Stroke
Y/N Surgical implant
Y/N Thyroid disease hyper/hypo
Y/N Seizure
Y/N Tuberculosis
Y/N Ulcers / colitis
Y/N Venereal disease

Are you currently taking any medications? Y/N If yes, list all:

_____

Do you have any drug allergies? Y/N If yes, list all:

_____

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the treating dentist to help determine the most appropriate and healthful dental treatment. I understand that if there is any change in medical status I must inform the dentist.

Signature _____ Date: _____

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Financial Policy

All co-payments are due at the time services are rendered.

As a condition of your treatment by this office, financial agreements must be made in advance. Our office accepts assignment of insurance benefits. We verify eligibility and coverage for all insurances: if your insurance is expected to pay a portion of your bill, we will wait for that portion from them. It is your responsibility to pay any co-pays, deductibles, or any amounts not expected from your insurance at the time treatment is provided. If your insurance company has not paid the full balance within 60 days, the balance of your account will become your responsibility. If you do not have insurance, or if our office does not accept assignment from your insurance company then payment is due in full at the time of treatment.

We are a third party administrator of your insurance carrier and are NOT responsible for how your insurance handles your claims or how benefits are assigned. We can assist in estimating the cost of your portion of treatment, but cannot be responsible for any changes in your insurance policy or benefits used elsewhere. It is your responsibility to let us know if there are any changes to your insurance, if your policy is terminated, or if you have used benefits elsewhere. Please remember that insurance is a contract between you and your insurance company, our office is not a part of this contract. You are responsible for the timely payment of your account.

Our office accepts cash, Visa, MasterCard, Discover, American Express, and Care Credit. We do not accept check payments.

In this office we believe in providing our patients with the utmost care. This means using the best materials available in order to promote and preserve a healthy smile. We understand that your dental insurance may downgrade to amalgam (metal) fillings, however this is a mercury free office, therefore the patient is responsible for any difference in cost.

X-rays and Photographs Policy

I authorize Woodlake Family Dental to take any x-rays and photographs deemed necessary for the detection and diagnoses of oral decay and disease. I authorize the release of this and any other information to my insurance company necessary to processing my dental claim in accordance with HIPAA regulations.

Cancellation Policy

If you find it impossible to keep an appointment, for consideration of other patient's needs, we ask for at least a 48 hour notice. Appointments cancelled or missed without a 48 hour notice are subject to a fee. We believe the dental appointment represents a shared responsibility for both the doctor and the patient, in order to have quality dental care at an affordable cost these appointments must be kept. If you fail to confirm your appointments, our office reserves the right to cancel your appointment or those of your family members. After two missed appointments, we will no longer be able to reserve appointment time for you in advance.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all insurance submissions.

Signature _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I _____, hereby acknowledge receipt of Woodlake Family Dental's Notice of Privacy Practices detailed information about how the office may use and disclose my confidential information.

Patient Name: _____

Relationship to patient: _____

Signature _____ Date: _____

Request for Confidential Communications

Written Communications:

If the address provided on the first page is **not** your home address, please provide us with a street address for purposes of ensuring payment and appointment reminders.

_____

The best way for Woodlake Family Dental's staff to contact me is by: (Circle one) Home # Cell # E-mail

Oral Communications:
May we leave a message at the numbers provided for the following?

Home # : Yes / No Cell # : Yes / No

May we leave a message that you need to pre-medicate? Yes / No

May we leave a message that you have a dental appointment? Yes / No

May we leave a message that you require a dental appointment? Yes / No