WELCOME!

Thank you for choosing our office. We strive to provide you with the most gentle, quality care possible. If you have any questions, or we can help you in any way, please feel free to ask.

Patient Information (Confidential):

Name_____ (If child, parent/guardian name) _____
Last name First name Initial

Date of birth _____ Sex _____ Age _____ Soc. Sec. # _____

Home Address_____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

E-mail _____ Drivers License # _____

How would you like to be contacted for appointment reminders? □ E-mail □ Text message □ Home Phone □ Cell Phone □ Work Phone

Employer _____ Occupation _____ How long there? _____ May we call? _____

Employer Address _____ City _____ State _____ Zip _____

Spouse's Name (Or other parent/guardian) _____ Soc. Sec. # _____

Spouse's Employer _____ Occupation _____ How long there? _____ May we call? _____

Spouse's Employer Address _____ City _____ State _____ Zip _____

If patient is a student: Name of school/college: _____City & State _____

How did you hear about our practice? _____

Primary Dental Insurance:

Name of insured_____

Birthdate _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Co. _____ Phone _____

Soc. Sec. # _____ Subscriber ID # _____

Group, Contract or Union Local # _____

Additional Dental Insurance:

Name of insured _____

Birthdate _____ Relationship to patient _____

Address (if different from patient) _____

Dental Insurance Co. _____ Phone _____

Soc. Sec. # _____ Subscriber ID # _____

Group, Contract or Union Local # _____

In Case of Emergency:

Name and city of primary care physician _____

Someone we may contact, not living with you _____ Phone #'s (home, work, cell) _____

Authorization:

I authorize my insurance company to make payments directly to Woodland Family Dental. I authorize release of my records to third party payers, other healthcare professionals or operations, or other entities as deemed necessary by this office. I authorize use of this signature for all insurance submissions.

I understand that I am responsible for all charges whether or not they are covered by insurance, as well as any additional collection costs if this office determines they are necessary. I authorize this office to charge my credit card or bank account for any unpaid balances, including those after insurance payment. I further authorize Woodland Family Dental to charge my credit card to cover any unpaid fees not paid by insurance within 60 days. I have reviewed the information on this form, and it is accurate to the best of my knowledge.

Signature _____ Date _____

DENTAL HISTORY

Patient Name _____ Age _____ Date _____

Reason for seeking care today: _____Exam _____ Cleaning _____ Specific Problem

Please check all that apply:

□ Toothache
□ Broken filling or tooth
Sensitivity to:
  □ Cold
  □ Hot
  □ Sweets
  □ Chewing
□ Food catches
□ Loose teeth
□ Floss breaks easily or hurts
□ Bite or teeth have shifted
□ Often bite cheeks
□ Frequent dry mouth
□ Concerned about breath
□ Unhappy with previous dental work
□ Gums bleed
□ Gums tender
□ Growths, sores
□ Cold sores, fever blisters
□ Cracked, chapped lips
□ Bad taste in mouth
□ Sinus problems
□ Mouth breathe – difficulty breathing through nose
□ Dry or strained eyes
□ Shoulder, neck or headaches
□ Clench or grind teeth
□ Jaw joint pain
□ Clicking or popping of joint
□ Unable to open mouth wide
□ Jaw gets tired easily
□ Hold things between teeth (pipe, pencil, nails, pins)
□ Bite fingernails
□ Unusual habits with teeth
□ Wore braces
□ Previous gum treatment
□ Previous bite treatment

Would you like whiter teeth? _____ Is there anything that bothers you (even just a little) about the appearance of your teeth or smile?

_____

Please rate 1-10 how anxious you are about dental treatment (1=total relaxed) _____

Have you ever had a bad experience at the dentist? (Treatment, Staff, Billing) _____

Why did you leave your previous dentist? _____

Medical History

Physician's Name: _____

City _____ Phone _____

Have you been hospitalized for any reason? Please describe:
_____
_____

Are you taking any medications or drugs (including nutritional supplements) Please list: (Continue on back of form if needed)
_____
_____
_____

Are you allergic to penicillin, aspirin, local anesthetics, latex, sulfa, codeine, other? _____

Do you smoke? _____ How much/day? _____
Pregnant? _____ Due date _____ Are you nursing? _____
Are you seeing a physician now or planning to see one for any reason?
Please explain: (Continue on back of form if needed)
_____
_____
_____

Please check all that apply:

□ Previous injury to head or neck
□ Heart problem
□ Heart attack
□ Angina, chest pain
□ Heart murmur
□ Scarlet, Rheumatic fever
□ Mitral valve prolapse
□ Irregular heartbeat
□ Artificial joint
□ High or low blood pressure
□ Pacemaker
□ Diabetes
□ HIV or AIDS
□ Kidney problem
□ Liver problem, jaundice
□ Cirrhosis, hepatitis
□ Cancer, radiation, chemotherapy
□ Respiratory problem
□ Bloody, persistent cough
□ Sickle cell
□ Asthma, Emphysema
□ Anemia
□ Digestive problem, ulcer
□ Thyroid disease
□ Glaucoma
□ Bleed or bruise easily
□ Stroke
□ Epilepsy or seizures
□ Parkinson's
□ Alzheimer's
□ Dry eyes
□ Back problem
□ Hives, rash, herpes
□ Shortness of breath
□ Snoring, sleep apnea
□ No energy
□ Fainting or dizzy
□ Unexplained weight loss
□ Chewing tobacco
□ Drug or alcohol addiction
□ Two or more social drinks/day
□ Anxiety or nervous disorder
□ Insomnia

Any other illness not checked above? _____
Please indicate if you would like to speak privately with the dentist about a medical issue: □ Yes □ No
Please rate the following indicators of your daily stress level: 1-10 (1 = low, 10 = high)
_____Overworked, too busy, pressured _____Feel frustrated _____Get upset or "snap" easily _____Depression, anxiety

I will inform this office of any changes in my health status. I understand that dental treatment and local anesthesia entail risks such as bleeding, infection, nerve damage, or fracture of teeth or bone. I certify that the above information is complete and accurate to the best of my knowledge.

Patient Signature (parent or guardian) _____ Date _____

Dentist Signature _____ Date _____

FINANCIAL POLICY

Payment in full or co-payment is expected in full at the time of service.

We accept cash, personal checks, Visa, Master Card, American Express and Discover.

We also offer the Care Credit option which is a dental credit card. Applications are available at our office.

Many dental offices have refused to accept dental insurance due to the difficulty in receiving payment. Our office continues to offer the service of processing your dental claims at no charge. As a convenience to you, we ask that you participate in keeping a credit card on file for any remaining balances. You will be responsible for the full amount if for whatever reason your insurance company does not pay. We appreciate your cooperation in this matter, so our office can continue to offer the services of processing your insurance claims for you.

A monthly charge of 1 ½% will be added to all unpaid balances.

Repeated failed appointments are charged $35.00, kindly give at least 24 hours notice.

Returned check fee is $25.00.

I have read the above and understand what my responsibility is regarding payment of dental treatment.

_____
Patient Signature

Credit card authorization:

Card #_____ Card type_____ Exp_____

NOTICE OF PRIVACY PRACTICES

Woodland Family Dental

With your consent, we may use health information about you for treatment (such as sending your medical record information to a specialist physician as part of a referral), to obtain payment for treatment (such as sending billing information to a health plan), for administrative purposes, and to evaluate the quality of care that you receive (such as comparing patient data to improve treatment methods).

_____ _____

Patient Signature Date

_____ _____

Witness Date