

# Thank you for selecting DENTAL WELLNESS CENTER .

We will strive to provide you with the best possible care. To help us meet your entire healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask & we will be happy to help.

Date \_\_\_\_\_

## Patient/Guarantor Information

Check Appropriate Box    Minor    Single    Married    Divorced    Widowed    Separated

Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Soc Sec #: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Banking Institution \_\_\_\_\_

Patient/Guarantor Employer \_\_\_\_\_ Work Ph \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Guarantor Email Address \_\_\_\_\_

**SPOUSE, PARENT, OTHER-Relationship to patient** \_\_\_\_\_

Name \_\_\_\_\_ DOB \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Soc Sec #: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Banking Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Ph \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ St \_\_\_\_\_ Zip \_\_\_\_\_

Email Address \_\_\_\_\_

If Patient is a Student, Name of School/College \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Non Family Member Contact \_\_\_\_\_

Phone \_\_\_\_\_ Address \_\_\_\_\_

Who is responsible for the patient's medical care? \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

DENTAL WELLNESS CENTER

MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin, Penicillin, Codeine, Local Anesthetics, Acrylic, Metal, Latex, Sulfa drugs, Other

- Do you have, or have you had, any of the following? AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pacemaker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, High Cholesterol, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Osteoporosis, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Have you ever had any serious illness not listed above?

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

**DO YOU HAVE ANY ADDITIONAL INSURANCE?**    Yes    No    If YES, Complete the following:

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

DOB \_\_\_\_\_ Soc Sec # \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Name of Employer \_\_\_\_\_

Insurance Company \_\_\_\_\_

## *Authorization and Release*

*I certify that the information provided above is true and correct to the best of my knowledge and belief. I authorize the physician to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the physician's office, insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance and balances. I personally agree to pay for any and all services provided to me at the rates in effect during the time services are rendered. I understand and agree that my bill for services rendered is due and payable at the time of service and that I am ultimately responsible for any unpaid balances. A wide variety of means for communication exists and continues to broaden and develop. By signing this Authorization, I agree that this office, and any third party used for treatment, billing, collection and other services, may use any means of communication with me. Thus, I understand and agree that any phone numbers and email addresses provided by myself to this office and to any of our service providers, now and in the future, may be used as a means to contact me, and that this office and our service providers may leave messages for me manually and by using automated systems such as by artificial or prerecorded voice. Specifically, if I provide a cellular phone number, I consent and agree to accept collection calls and other communications to my cellular phone from this office and from any of our service providers. For any landline and cellular phone calls this office or any service providers place to me, I consent and agree that those calls may be automatically dialed and that this office and our service providers may use recorded messages. I also agree that this office and any service providers may contact me by sending text messages and emails to any phone number or email address I provide to this office or service providers, and I consent to receive such text messages and emails which may identify the name of this office or service provider sending the communication, and which may disclose the nature of the communication.*

**I give you permission to discuss my treatment and healthcare needs with the following person(s):**

\_\_\_\_\_

X \_\_\_\_\_

Signature of Patient/Guarantor