Chart#________________________________
FOR OFFICE USE ONLY

PATIENT INFORMATION

Patient Name:____Date:_________________________

Gender:______________Family Status:____

Social Security #:____________________Birth Date:___________________Drivers Licence #:____________________

E-mail Address:______________________________*Circle Preferred Method*: Home# Cell# Text or Email

Home Phone:________________________________Cell Phone:____

Work Phone:____

Address:____
Street Apartment #

____
City State Zip Code

Health Information

Have you ever had any of the following? Please check YES or NO:

YES	NO	
		Have you ever been told by your doctor that you need to take antibiotics prior to your dental appointment?
		Artificial Heart Valve
		Pacemaker
		Heart Murmur or Mitral Valve Prolapse
		Artificial Joints
		Heart Disease
		Rheumatic Fever
		HIV (+)
		Stroke
		Excessive Bleeding
		Prolonged Bleeding
		High Blood Pressure
		Do you take ANY blood thinners?
		Diabetes
		Tuberculosis
		Dizziness/Loss of Balance
		Jaw Locking/Catching
		Earaches
		Neck Pain
		Tired Jaw Muscles
		Change in Bite
		Neck Stiffness
		Jaw Clicking/Popping
		Headaches **If so how often?: ___________________________**
		Ringing in Ears **If so how often?: ___________________________**
		Clenching/Grinding **Day or Night?:______________________________**
		Do you drink carbonated beverages? (I.e. Coke)

YES	NO	
		Kidney Disease
		Hepatitis
		Asthma
		Have you ever had periodontal therapy?
		Penicillin Allergy
		Codeine Allergy
		Radiation Treatment
		Ulcers
		Tumors
		Do you chew gum? (Sugar or sugar free)
		Do you chew on candy or mints?
		Do you suck on fruits? (Lemons, limes, oranges)
		Do you bite your nails?
		Do you smoke?
		Do you chew tobacco?
		Do you take Bisphosphonate for osteoporosis? If yes: IV_____ or Oral Tablets_____
		Pregnancy DUE:___________________________
		Surgeries
		Allergies (Please Explain)
		Sleep Apnea Dr. for Sleep Apnea: ________________________

OTHER INFORMATION WE SHOULD BE AWARE OF?

 Patient's Name: ______________________________ **Date:** ________________________________

Have you ever had any complications following dental treatment? YES NO
If yes, please explain:

____

Have you been admitted to a hospital or needed emergency care during the past two years? YES NO
If yes, please explain:

____

Are you now under the care of physician? YES NO
If yes, please explain:

____

Are you currently taking any medication? YES NO
If yes, please list ALL medications and explain the reason for taking the medication:

____

____

Name of physician: ____________________________________ Phone: ______________________

Do you have any health problems that need further clarification? YES NO
If yes, please explain:

____

____

On a scale of one to ten (ten being the highest), how would you rate your overall dental health? __________

Are you happy with the color of your teeth?: ____

In there anything you would like to change about your teeth? ______________________________

Have you ever considered have a smile makeover? ____

So that we may assist our patents with the finance portion of their visit, we are pleased to offer an interest free financing program through care credit.

Would you like to apply for your pre approved (Care Credit) interest free financing program? ____________

To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ ________________
Signature of Patient Date

____________________________ ____________________________ ________________
Name of Parent of Guardian (Please Print) Signature of Parent or Guardian Date

 Patient's Name: ____________________________ **Date:** ______________________________

Referral Information

Whom may we thank for referring you to our practice?

Dr: ______________________________ Patient: ____

Insurance Website Mailer Internet Groupon Other: ______________________________

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed.

In consideration for the professional services rendered to me, or at my request by the Doctor, I agree to pay the value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree that the value of said services shall be as billed unless objected to, by me, in writing, within the time of payment thereof. I further agree that a waiver of any break of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all cost including attorney fees if suit be instituted hereunder.

Insurance: Dental insurance is a contract between you and the insurance company. Despite our efforts, there is no guarantee of benefits or reimbursement. As a courtesy, we will bill you insurance company on your behalf. If your insurance company has not made payment within 30 days, the outstanding balance becomes your responsibility. I fully understand and agree my financial arrangements and obligations with Weninger Dentistry supersede any and all insurance contracts that either I or Weninger Dentistry may have signed. I authorize Weninger Dentistry to send any and all dental information to my insurance company.

Collections: A service charge of (21% per annual) on the unpaid balance as well as $5.00 per month late fee will be charged on all accounts exceeding 7 days past due. If balance is outstanding longer than 7 days, Patient agrees to pay all fees, including but not limited to: late fees, interest fees, as well as attorney and/or collections fees totalling an additional fee of 50% of outstanding debt. Report to a collection agency may also occur if balance has not been paid after 45 (forty-five) days.

No Shows/Appointment Cancellations: We respectfully request a 48-hour notice if you cannot keep your scheduled appointment. This will allow us not only to serve those patients who are on a waiting list, but will prevent your account from receiving a No Show/ Cancellation fee of $35 or up to full visit fee, depending on the length of the appointment that was not kept. No show consist of not showing up for your scheduled appointment or calling less than 48 hours to cancel an appointment. We do understand that medical or family emergencies do arise, therefore exceptions to this policy will be handled on a case by case basis. Please note: patients with **three no show appointments** will be asked to transfer their records to another dentist.

I have read the above conditions of treatment and payment and agree to their content.

____ ____________________

Signature of Patient Date

______________________________ ______________________________ ____________________

Name of Parent of Guardian (Please Print) Signature of Parent or Guardian Date

 Patient's Name: ______________________ **Date:** ______________________

HIPAA

I, ______________________, have read a copy of the Health Insurance Portability and Accountability Act (HIPAA). I understand that if I wish to have a personal copy, one will be provided to me.

Telephone, Email and/or Text Messages:

I grant my permission to you or your assignee(s), to contact me (including leaving messages on my voicemail, email, text or with any individuals answering the phone) related to any of my dental records, dental treatment, account balance, account collection matters, dental appointments, or any other dental matter.

Reminder Cards:

I grant permission to send reminder postcards for scheduled and/or unscheduled appointments which will state the date, time, and/or type of appointment.

Persons requesting patient information:

I understand that Weninger Dentistry will not release any dental information such as: necessary treatment, procedure fees appointment information (including but not limited to: date and time of appointment or reason for the appointment), to any individual who is personally requesting the above information unless I have authorized this office to do so.

Authorization to release information to individuals requesting dental records:

I,______________________, authorize Weninger Dentistry to release ANY and ALL dental information to the following people. I also understand that Weninger Dentistry will not be held responsible for verifying identification the the individuals listed below.

Name: ______________________
(Please Print) *(Friend or Family Member)*

Name: ______________________
(Please Print) *(Friend or Family Member)*

______________________ ______________
Signature of Patient Date

______________________ ______________________ ______________
Name of Parent of Guardian (Please Print) Signature of Parent or Guardian Date

I understand that by signing this form, I am verifying that I have received and/or read a copy of the Health Insurance Portability and Accountability Act (HIPAA) and I have read the above office policy and agree to their content.

______________________ ______________
Signature of Patient Date

______________________ ______________________ ______________
Name of Parent of Guardian (Please Print) Signature of Parent or Guardian Date