Chart #: _____
FOR OFFICE USE ONLY

Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: Family Status:

Social Security #: _____ Birth Date: _____ *Drivers License#* _____

E-mail Address _____ ***Circle Preferred Contact Method****: Home* ☐ *Cell* ☐ *Text* ☐ *Email* ☐

Phone (Home): _____ Cell Phone _____
(Work): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

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

YES	NO		YES	NO	
○	○	Have you ever been told by your Dr. that you need to take antibiotics prior to your Dental appointment?	○	○	Kidney Disease
○	○	**Artificial Heart Valve**	○	○	Hepatitis
○	○	Pacemaker	○	○	Asthma
○	○	Heart Murmur or Mitral Valve Prolapse	○	○	Have you ever had periodontal therapy?
○	○	Artificial Joints	○	○	Penicillin Allergy
○	○	Heart Disease	○	○	Codeine Allergy
○	○	Rheumatic Fever	○	○	Radiation Treatment
○	○	HIV (+)	○	○	Ulcers
○	○	Stroke	○	○	Tumors
○	○	Excessive Bleeding	○	○	Do you bite your nails?
○	○	Prolonged Bleeding	○	○	Do you smoke?
○	○	High Blood Pressure	○	○	Do you chew tobacco?
○	○	**Do you take ANY Blood Thinners?**	○	○	**Do you take Bisphosphonate for Osteoporosis?**
					If yes: ☐ IV ☐ Oral tablets
○	○	Diabetes	○	○	**Pregnancy** Due _____
○	○	Tuberculosis			
○	○	Dizziness/Loss of Balance	○	○	Surgeries_____
○	○	Jaw Locking/Catching			_____
○	○	Earaches	○	○	Allergies(Please Explain)_____
○	○	Neck Pain			_____
○	○	Tired Jaw Muscles			
○	○	Change in Bite			
○	○	Neck Stiffness	○	○	Sleep Apnea
○	○	Jaw Clicking/Popping			Dr. For Sleep Apnea_____
○	○	Headaches (IF SO HOW OFTEN)_____			**OTHER INFORMATION WE SHOULD BE AWARE OF?**
○	○	Ringing in Ears (IF SO HOW OFTEN)_____			
○	○	Clenching/Grinding (DAY OR NIGHT)_____			
○	○	Do you drink carbonated beverages (i.e. Coke)			
○	○	Do you chew gum? (Sugar or Sugar free)			
○	○	Do you chew on candy or mints?			
○	○	Do you suck on fruits (lemons, limes, oranges)?			

 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 a 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?_____

On a scale of one to ten, (Ten being the highest) how would you rate your teeth?_____

Are you happy with the color of your teeth?_____

Is there anything you would like to change about your teeth?_____

Have you ever considered having a smile makeover?_____

(So that we may assist our patients 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 proceeding 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 or 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?

☐ Patient: _____ ☐ Insurance Company Website ☐ Internet ☐ Mailer ☐ 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 for payment thereof. I further agree that a waiver of any breach 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 your 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 totaling 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 consists 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 bases. 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.

_____ **Date:** ____

Signature of patient

_____ _____ Date*:* _____

Name of Parent or Guardian: (please print) Signature of Parent or Guardian

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 voice mail, email, text or with any individual 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 Emails, Texts or Cards:

I grant permission to send reminder emails, texts or 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 on the individuals listed below.*

Name of Friend, Family Member or Other:

*Name:*_____*(relationship)*
(Please Print)

*Name:*_____*(relationship)*
(Please Print)

_____ **Date*:*** _____
Signature of patient

_____ _____ Date_____
Name of Parent or Guardian: (please print) Signature of Parent or Guardian

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.

_____ **Date*:*** _____
Patient's Signature

_____ _____ Date: _____
Name of Parent or Guardian (please print) Signature of Parent or Guardian