**Patient Registration and Health History**

DATE: \_/ / NAME: First MI Last

REFERRED BY:

**CONTACT INFORMATION PREFERRED NAME:\_**

Ext

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PHONE: HOME ( | ) | - | CELL ( | ) | - |  | WORK ( | ) | - |
| ADDRESS: |  |  |  |  |  | CITY |  |  | STATE |

ZIP

E-MAIL ADDRESS:

MAY WE “TEXT” MESSAGE YOU?

Yes No

EMERGENCY CONTACT: NAME:

(Someone who does not live in your household)

RELATIONSHIP

PHONE: HOME ( ) -

WORK/CELL ( ) -

Ext

## PERSONAL INFORMATION

BIRTHDATE:

/\_

/\_

SOCIAL SECURITY #:

/ /

SEX: M F

MARITAL STATUS:

Married

Single

Divorced

Widowed

Separated

Partnered

years

\_ Minor

EMPLOYER/SCHOOL:

OCCUPATION:

EMPLOYER ADDRESS:

CITY

STATE

ZIP

## SPOUSE/PARENT/GUARDIAN INFORMATION

NAME:

RELATIONSHIP TO PATIENT:

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| EMPLOYER: |  |  |  |  | ADDRESS: |  | | |
| BIRTHDATE: | /\_ | /\_ | DAYTIME PHONE: ( | ) | - | SOCIAL SECURITY #: | / | / |

## DENTAL HEALTH HISTORY

REASON FOR TODAY’S VISIT:

FORMER DENTIST:

CITY

STATE

DATE OF: LAST VISIT: /

**MEDICAL HEALTH HISTORY**

**Have you ever responded adversely to dental treatment? Yes No If yes, Please explain…**

LAST DENTAL X-RAYS: /

HOW OFTEN DO YOU BRUSH?

FLOSS?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **PLEASE MARK ALL THAT APPLY…**  Bad Breath |  | Bleeding gums |  | Blister on lips/mouth |  |
| Burning sensaGon on tongue Clicking/popping jaw |  | Chew on one side Dry mouth |  | Smoker Fingernail biGng |  |
| Food collects between teeth |  | Foreign Objects |  | Grinding of teeth |  |
| Gums swollen or tender |  | Jaw pain or Gredness |  | Lip or cheek biGng |  |
| Loose teeth or broken fillings |  | Mouth breathing |  | Mouth pain – brushing |  |
| OrthodonGc treatment |  | Pain around ear |  | Periodontal treatment |  |
| SensiGvity to cold |  | SensiGvity to heat |  | SensiGvity to sweets |  |
| SensiGvity when biGng |  | Sores in mouth |  | Growths in mouth |  |

DATE: \_/ / NAME: First MI Last

PHYSICIAN: Name

City

State

Medical Group

OFFICE PHONE: (\_ ) -

Date of Last visit:

\_ \_/

\_/

Were there any special concerns?

Yes No

### PLEASE MARK ALL THAT APPLY…

(f

AIDS/HIV

Artificial Heart Valves Back problems Cancer

Circulatory problems Cortisone treatments Diabetes

Fainting or dizziness Heart murmur High blood pressure Kidney disease

Mitral valve prolapse Psychiatric care Rheumatic fever Sinus trouble Stroke

Thyroid problems

Tumor/growth-head or neck

Unexplained weight loss/gain

Anemia

Artificial joints

Bleeding abnormalities

Chemical dependency Congenital heart lesions Cough, persistent Emphysema

Glaucoma

Hepatitis, type Jaundice

Liver disease

Nervous problems

Radiation treatments Scarlet fever

Skin rash

Swollen feet or ankles Tonsillitis

Ulcer

Sleep Apnea

Arthritis, Rheumatism Asthma

Blood disease

Chemotherapy

Contact lenses

Cough, bloody

Epilepsy Headaches Herpes Jaw pain

Low blood pressure Pacemaker

Respiratory disease

Shortness of Breath Special Diet

Swollen neck glands Tuberculosis

Venereal disease Snoring

Do you smoke (pipe, cigar, cigare-e?)

Yes

No If yes, How many per day?

Do you consume alcohol? Do you chew tobacco?

Yes

Yes

No If yes, How many drinks per week?

No If yes, How many times per week?

Had any major surgeries in the last 10 years? Have you ever taken “fen-Phen”?

Yes Yes

No Type & Date

No Year/s?

(These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine), and Redux (dexfenfluramine)

**WOMEN:** Do you suspect that you are pregnant?

\_Yes

No Due date

/\_

\_/

Are you currently nursing?

Yes No

**Are there any addioonal health concerns that you would like us to be aware of?**

**MEDICATIONS:** List **ALL** medications you are currently taking along with correlating diagnosis. **Please include herbal supplements. Drug Name: Dosage/mg/IU: How Taken:**

## ALLERGY / HYPERSENSITIVITY ALERT!

**PLEASE MARK ALL THAT APPLY…**

Aspirin

Codeine

Latex

Penicillin

Other:

Barbiturates (sleeping pills)

Iodine

Local Anesthetic Sulfa

PHARMACY NAME: LOCATION:

To the best of my knowledge, the information I have provided on this form is complete and accurate. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any errors or omissions that I may have made in completion of this form. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health status.

**SIGNATURE: DATE:**

# Financial Agreement

DATE: \_/ / PATIENT NAME: First MI Last

## PAYMENT RESPONSIBILITIES AND OPTIONS

#### This form has been prepared to acquaint you with our office policy regarding account balances not covered by insurance. Understanding our policy will make it easier for you to choose the treatment op,ons that best suit your specific dental needs and financial circumstance.

**INSURED ACCOUNT CHARGES: Will be submifed on your behalf (See responsible party statement)**

**Balance due in full within 30 days of applying insurance seflement\***

**UNISURED ACCOUNT CHARGES:**

**$500.00 or less Due in full on the day of service**

**Over $500.00 but less than $3,000.00 Half due on the day of service with balance due at delivery**

**$3,000.00 or more Individual payment arrangements will not exceed 90 days**

**ALL ACCOUNT BALANCES EXCEEDING 90 DAYS: Subject to an interest charge of 1.75% per month (21% annually)**

**EXTENDED PAYMENT PLAN OPTIONS: Offered through **

Our office is pleased to make **CareCredit** available in order to help you pay for treatment and procedure costs not covered by insurance. Through **CareCredit,** you may qualify for **No or Low Interest\* financing offering affordable monthly payment oppons with up to 60 months to pay.** In three simple steps that could bring instant approval, you can get the treatment you want, when you want it. We would be happy to assist you with the process or you can get informa,on and apply online by visi,ng ***CareCredit.com***

## FORMS OF PAYMENT ACCEPTED

### CASH, CHECK, MONEY ORDERS, DEBIT CARDS, MASTERCARD, VISA, DISCOVER, CARECREDIT, and most DENTAL INSURANCE.



**DISCOUNTS (Apply to Cash or Check transactions only)**

#### We offer a 5% discount to all pa,ents who have no outstanding balance and pay-in-full on the day of service.

We offer a 10% discount to all seniors (age 65 and over) who have no outstanding balance and pay-in-full on the day of service.

**RESPONSIBLE PARTY**

The responsible party is held liable for the en,re account balance. **\* Insurance delays, processing problems or lack of coverage does not exempt the responsible party from making payment in full within 90 days of service.** Any insurance overpayments will be promptly returned to the appropriate party. **The parent/guardian/personal representapve/relapve bringing the child(ren) to our office and requespng treatment will be considered the responsible party for the account balance in its enprety and will be billed accordingly.** Please be advised that all arrangements made through court order or otherwise are strictly between the par,es concerned and do not involve our office.

PERSON RESPONSIBLE FOR THIS ACCOUNT:

RELATIONSHIP TO PATIENT:

ADDRESS:

CITY

STATE

ZIP

EMPLOYER:

ADDRESS:

BIRTHDATE:

/\_ /

DAYTIME PHONE: (\_

\_) -

SOCIAL SECURITY #:

/ /

I acknowledge that I have carefully reviewed this **FINANCIAL AGREEMENT** along with the **INSURANCE ASSIGNMENT & AGREEMENT**

#### on the reverse side of this document and understand my responsibility as stated therein.

\_/

**SIGNATURE OF RESPONSIBLE PARTY**

/

**DATE**

# INSURANCE ASSIGNMENT & AGREEMENT

DATE: \_/ / PATIENT NAME: First MI Last

#### We are happy to assist you by submiNng insurance claims on your behalf and helping out with insurance problems as best we can. However, if an insurance payment is delayed or a company is slow to remit, payment is sAll expected on a Amely basis from the responsible party noted on the FINANCIAL AGREEMENT FORM. Please be aware that all deductable amounts and co-payments are due and payable at the Ame of service.

**INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY:**

#### SUBSCRIBER’S NAME:

INSURANCE COMPANY ADDRESS

EMPLOYER

Group #

ID #

IS THERE SECONDARY/CO-INSURANCE?

No

\_Yes (Complete secondary insurance company secAon below)

I cerAfy that I, and/or my dependent(s), have insurance coverage with the above listed insurance company and assign directly to **ROBERT H WAGNER FAMILY DENTISTRY SC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named denAst may also use my health informaAon and may disclose such informaAon to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will stay in effect unAl I choose to rescind such in wriAng.

/ /

**SIGNATURE OF INSURED SUBSCRIBER #1 - SELF/SPOUSE/PARENT/GUARDIAN DATE**

**SECONDARY INSURANCE COMPANY:**

SUBSCRIBER’S NAME:

INSURANCE COMPANY ADDRESS

EMPLOYER

Group #

ID #

I cerAfy that I, and/or my dependent(s), have insurance coverage with the above listed insurance company and assign directly to **ROBERT H WAGNER FAMILY DENTISTRY SC** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named denAst may also use my health informaAon and may disclose such informaAon to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will stay in effect unAl I choose to rescind such in wriAng.

/

**SIGNATURE OF INSURED SUBSCRIBER #2 - SELF/SPOUSE/PARENT/GUARDIAN**

/

**DATE**