Patient Registration and Health History

DATE: / / NAME: First MI Last

REFERRED BY: _____

CONTACT INFORMATION

PREFERRED NAME:_____

PHONE: HOME (_____) _____ -_____ CELL (_____) _____-_____ WORK (_____) _____-_____ Ext_____

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: _____/_____ LAST DENTAL X-RAYS: _____/_____ HOW OFTEN DO YOU BRUSH?_____ FLOSS? _____

PLEASE MARK ALL THAT APPLY…

Bad Breath	___	Bleeding gums	___	Blister on lips/mouth	___
Burning sensation on tongue	___	Chew on one side	___	Smoker	___
Clicking/popping jaw	___	Dry mouth	___	Fingernail biting	___
Food collects between teeth	___	Foreign Objects	___	Grinding of teeth	___
Gums swollen or tender	___	Jaw pain or tiredness	___	Lip or cheek biting	___
Loose teeth or broken fillings	___	Mouth breathing	___	Mouth pain – brushing	___
Orthodontic treatment	___	Pain around ear	___	Periodontal treatment	___
Sensitivity to cold	___	Sensitivity to heat	___	Sensitivity to sweets	___
Sensitivity when biting	___	Sores in mouth	___	Growths in mouth	___

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

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…

AIDS/HIV	___	Anemia	___	Arthritis, Rheumatism	___
Artificial Heart Valves	___	Artificial joints	___	Asthma	___
Back problems	___	Bleeding abnormalities	___	Blood disease	___
Cancer	___	Chemical dependency	___	Chemotherapy	___
Circulatory problems	___	Congenital heart lesions	___	Contact lenses	___
Cortisone treatments	___	Cough, persistent	___	Cough, bloody	___
Diabetes	___	Emphysema	___	Epilepsy	___
Fainting or dizziness	___	Glaucoma	___	Headaches	___
Heart murmur	___	Hepatitis, type ___	___	Herpes	___
High blood pressure	___	Jaundice	___	Jaw pain	___
Kidney disease	___	Liver disease	___	Low blood pressure	___
Mitral valve prolapse	___	Nervous problems	___	Pacemaker	___
Psychiatric care	___	Radiation treatments	___	Respiratory disease	___
Rheumatic fever	___	Scarlet fever	___	Shortness of Breath	___
Sinus trouble	___	Skin rash	___	Special Diet	___
Stroke	___	Swollen feet or ankles	___	Swollen neck glands	___
Thyroid problems	___	Tonsillitis	___	Tuberculosis	___
Tumor/growth-head or neck	___	Ulcer	___	Venereal disease	___
Unexplained weight loss/gain	___	Sleep Apnea	___	Snoring	___

Do you smoke (pipe, cigar, cigarette?) ___ Yes ___ No If yes, How many per day? _____

Do you consume alcohol? ___ Yes ___ No If yes, How many drinks per week? _____

Do you chew tobacco? ___ Yes ___ No If yes, How many times per week? _____

Had any major surgeries in the last 10 years? ___ Yes ___ No Type & Date _____

Have you ever taken "fen-Phen"? ___ Yes ___ 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 additional 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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY NAME:_____

LOCATION:

ALLERGY / HYPERSENSITIVITY ALERT!

PLEASE MARK ALL THAT APPLY…

Aspirin	___	Barbiturates (sleeping pills)	___
Codeine	___	Iodine	___
Latex	___	Local Anesthetic	___
Penicillin	___	Sulfa	___

Other:

_____

_____

_____

_____

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 options that best suit your specific dental needs and financial circumstance.

INSURED ACCOUNT CHARGES:	**Will be submitted on your behalf (See responsible party statement)** **Balance due in full within 30 days of applying insurance settlement***
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 CareCredit**

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 options 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 information and apply online by visiting ***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 patients 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 entire 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 representative/relative bringing the child(ren) to our office and requesting treatment will be considered the responsible party for the account balance in its entirety and will be billed accordingly.** Please be advised that all arrangements made through court order or otherwise are strictly between the parties 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 submitting 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 still expected on a timely 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 time 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 section below)

I certify 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 dentist may also use my health information and may disclose such information 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 until I choose to rescind such in writing.

_____ _____/_____/_____

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

SECONDARY INSURANCE COMPANY: _____ SUBSCRIBER'S NAME: _____

INSURANCE COMPANY ADDRESS _____

EMPLOYER _____ Group # _____ ID # _____

I certify 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 dentist may also use my health information and may disclose such information 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 until I choose to rescind such in writing.

_____ _____/_____/_____

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