

Wooster Family Dental
3431 Commerce Parkway
Suite A
Wooster, OH 44691
(330) 264-8973

Patient Information

Thank you for choosing our practice for your dental needs. Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: Date:

SSN: Gender: Male/Female - Family Status: Married Single Child Other

Date of Birth: E-mail:

Phone: Home: Cell: Work:

Address: City: State: Zip:

Emergency Contacts:

Name: Phone: Relationship:

Name: Phone: Relationship:

Who referred you to Wooster Family Dental?

Expectations

We respect our patients' time. Therefore we do everything we can do to work efficiently on treatment. We request the same from you. Please be on time and give us a 48 hour notice if you need to adjust any appointment. All broken appointments will result in a \$35.00 fee. Please initial:

We are a zero-balance office. If there is an investment in your health, what method of payment would you use? Please Circle: Cash Credit Check Financing (Care Credit) HSA

Please initial here if you do not have Dental Insurance/Self-Pay Status:

Dental Insurance Information
(Please provide a copy of your Dental Insurance card)

Name of Policy Holder: Birth Date:

Member ID/SSN #: Group #:

Policy Holder's Employers Name:

Patient's Relationship to Policy Holder: Self Spouse Child Other

Insurance Company: _____ Insured's SSN: _____

Insurance Co. Mailing Address: _____

Health Information

1. Are you taking prescription(s)/over-the-counter or supplement drugs? **YES/NO** If yes, please list medications below:

2. Do you have any allergies? **YES/NO** If yes, please circle all that apply: Penicillin Antibiotics Anesthetics Aspirin Foods Latex Resins Other: _____
3. Do you require antibiotics before dental treatment? **YES/NO**
If yes, what premedication (antibiotic) have you been prescribed & who is your prescriber? _____
4. **Women:** Are you pregnant? **YES/NO** Trying to get pregnant? **YES/NO** Are you taking oral contraceptives? **YES/NO**
5. Symptoms or conditions below that you currently HAVE or HAVE HAD in the past year(s): (Please listed the Year Diagnosed (DX))

Alcohol Abuse: Yes/No Year Dx: _____	Rheumatic Fever: Yes/No Year Dx: _____	Allergies to Medicine(s) : Yes/No Year Dx: _____
Drug Abuse: Yes/No Year Dx: _____	Glaucoma: Yes/No Year Dx: _____	Sinus problems: Yes/No Year Dx: _____
Osteoarthritis: Yes/No Year Dx: _____	Hepatitis A, B, C: Yes/No Year Dx: _____	Thyroid Disease: Yes/No Year Dx: _____
Anemia: Yes/No Year Dx: _____	Shingles: Yes/No Year Dx: _____	Asthma: Yes/No Year Dx: _____
Liver Problems: Yes/No Year Dx: _____	Kidney Disease: Yes/No Year Dx: _____	AIDS/HIV/STDs: Yes/No Year Dx: _____
Tobacco Habit: Yes/No Year Dx: _____	Ulcers/Colitis: Yes/No Year Dx: _____	Psychiatric Care: Yes/No Year Dx: _____
Osteoporosis: Yes/No Year Dx: _____	Back Problems: Yes/No Year Dx: _____	
Stroke: Yes/No Year Dx: _____	Rheumatoid Arthritis: Yes/No Year Dx: _____	
Artificial Joints: Yes/No Year Dx: _____	Blood Pressure (High/Low): Yes/No Year Dx: _____	
Tuberculosis: Yes/No Year Dx: _____	Diabetes (I/II/III): Yes/No Year Dx: _____	
Heart Murmur: Yes/No Year Dx: _____	Epilepsy: Yes/No Year Dx: _____	
Heart Ailments/Heart Attack: Yes/No Year Dx: _____		
Mitral Valve Prolapse: Yes/No Year Dx: _____		

6. Do you have any other health conditions? **YES/NO** If yes, please explain:

7. Are you currently Taking bisphosphonate /Fosamax? **Yes/No**
8. Do you have history of cancer/chemotherapy/radiation? **YES /NO** Are you currently receiving treatment? **YES/NO**
9. Have you ever been a recipient of an organ transplant? **YES/NO** _____
10. Primary Care Physician _____ Phone Number _____

Consent for Services

As a condition of treatment by this office, **financial arrangements must be made in advance**. The practice depends upon reimbursement from 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 cash/check/credit card at the time services are performed unless other arrangements are made.

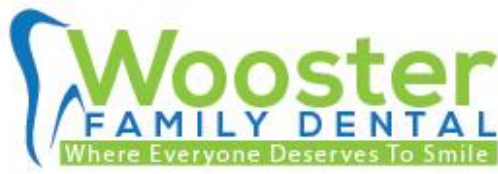
Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the

patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

In consideration for the professional services rendered to me this practice, I agree to pay the charges for the services at the time of treatment, or within ten (10) days of billing, 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 costs and reasonable attorney fees if suit be instituted hereunder. **A \$10.00 late payment fee may be added at our discretion to late accounts, unless previously written financial arrangements are satisfied.**

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

Signature: _____ **Date:** _____



HIPAA Acknowledgement

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient’s rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? **YES / NO**

May we leave a message on your answering machine at home or on your cell phone? **YES / NO**

May we discuss your medical condition with any member of your family? **YES / NO**

If YES, please name the members allowed:

Signature of patient, parent, or guardian (responsible party):

Signature: _____ Date: _____