Wellwood Family Dentistry

PATIENT REGISTRATION

Patient Information

Name: _____ Address: _____

City: _____ State: _____ Zip: _____-_____ Email: _____

Home #: _____ Work #: _____ Ext.: _____ Cell #: _____ Preferred: ❑Cell ❑Work ❑Home

❑Male ❑Female ❑Other: _____ ❑Married ❑Single ❑Divorced ❑Separated ❑Widow

Birth Date: _____ Age: _____ Soc. Sec.: ____-____-____ Driver's License #: _____ State: _____

Employer: _____ Occupation: _____ Preferred correspondences: ❑Email ❑Text ❑Call

Employment Status: ❑Full Time ❑Part Time ❑Retired Emergency Contact: _____

Student Status: ❑Full Time ❑Part Time Contact Phone: _____

Who may we thank for referring you? _____ Preferred Pharmacy: _____

Insurance Information

Primary Insurance

Name of Subscriber: _____ Pt./Subscriber Relationship: ❑Self ❑Spouse ❑Child ❑Other

Subscriber DOB: _____ Employer: _____ Insurance Co.: _____

Subscriber SSN #: _____ Member ID.#: _____ Group #: _____

Secondary Insurance

Name of Subscriber: _____ Pt./Subscriber Relationship: ❑Self ❑Spouse ❑Child ❑Other

Subscriber DOB: _____ Employer: _____ Insurance Co.: _____

Subscriber SSN #: _____ Member ID.#: _____ Group #: _____

Although dental professionals primarily treat the area in and around your mouth, your mouth is part of your entire body. Health problems that you may have, or medications that me taking, could have an important interrelationship with the dentistry you will receive. Your answers will be kept confidential, subject to applicable laws.

PATIENT MEDICAL HEALTH HISTORY

Primary Physician: _____ Phone: _____ City: _____ State: _____

Specialist: _____ Phone: _____ City: _____ State: _____

❑ Cardiologist ❑Endocrinologist ❑ Orthopedist ❑ Other: _____ Last Physical Exam: _____

Please list any current medications: _____

_____

_____

Do you need to be pre-medicated for dental procedures? ❑ Y ❑ N If so, what antibiotic? _____

How would you rate your general health? ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you allergic to any of the following? Please check Yes or No:

	Yes	No		Yes	No		Yes	No		Yes	No
Aspirin			Penicillin			Codeine			Acrylic		
Metal			Latex			Sulfa Drugs			Local Anesthetic		
Other:											

Women, are you: ❑Pregnant ❑Trying to become pregnant ❑Nursing ❑Taking oral contraceptives

PATIENT MEDICAL HEALTH HISTORY	Yes	No	If yes, please explain:
Are you currently under the care of a physician?			
Have you ever been hospitalized or had a major operation?			
Are you on a special diet?			
Do you smoke, chew tobacco or vape?			
Do you use controlled substances?			
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?			
Have you been treated with radiation or chemotherapy?			
Are you taking blood thinners?			

Do you have, or have you had, any of the following? Please Check Yes or No:

	Yes	No		Yes	No		Yes	No		Yes	No
Heart Attack			Stroke			Hepatitis A, B, or C			Visual changes		
Heart Pacemaker			Headaches			Ulcers			Glaucoma		
Coronary ♥ Disease			Epilepsy or Seizures			Kidney Disease			Sinus Problems		
Congenital ♥ Defect			Numbness/Tingling			Cold Sores			Throat Soreness		
High Blood Pressure			Shingles			Sickle Cell Disease			Weight Change		
Artificial Valve			Sleep Apnea			Anemia			Persistent Fever		
Heart Surgery			Tuberculosis			Low Blood Sugar			AIDS / HIV Positive		
Chest Pains			Emphysema			Excessive Bleeding			Drug Addiction		
Irregular Heartbeat			Asthma / Hay Fever			Leukemia			Cancer		
Congestive ♥ Failure			Persistent Cough			Rash / Hives			Chemotherapy		
Diabetes			Arthritis / Gout			Skin Color Change			Radiation Treatment		
Thyroid Disease			Artificial Joint			Anaphylaxis			Tumors or Growths		
Alzheimer's Disease			Osteoporosis			Low Blood Pressure			HPV		
Any other medical issues?											

PATIENT DENTAL HEALTH HISTORY

Date of last dental exam: _____ Date of last professional cleaning: _____

Previous Dentist: _____ City: _____ State: _____

Notable dental procedures: _____

I routinely see my dentist every: ❑ 3 months ❑ 6 months ❑ 12 months ❑ Other: _____

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Have you ever been told you have periodontal disease (gum disease)? ❑ Yes ❑ No

Have you had, or are you currently experiencing, any of the following? Please check all that apply:

Bad Breath		Grinding Teeth		Sensitivity to Cold		Jaw Pain	
Sensitive Chewing		Sensitive Biting		Sensitivity to Heat		Loose Teeth	
Broken Teeth		Sores or Lesions		Sensitivity to Sweets		Bleeding Gums	
Discolored Teeth		Abscess		Toothache		Pain in Jaw Joint	
Dentures		Partials		Braces		Migraines	

On a scale of 1 – 10, with 10 being the highest rating:

How important is your dental health to you?	1	2	3	4	5	6	7	8	9	10
Where would you rate your current dental health?	1	2	3	4	5	6	7	8	9	10
How happy are you with your smile?	1	2	3	4	5	6	7	8	9	10

PATIENT DENTAL HEALTH HISTORY	Yes	No	If yes, please explain:
Have you ever had a bad dental experience?			
Has fear/anxiety ever stopped you from having dental treatment?			
Do you have all your teeth? If not, which are missing?			
Do you have oral habits which might affect your oral health (i.e. pipe smoking, playing musical instruments, biting fingernails)?			
Do you avoid chewing on one side of your mouth?			
Have you had complications with past dental treatment?			
Have you had trouble getting numb?			
Does food get trapped between your teeth?			
Have you ever whitened or bleached your teeth?			
Do you wear a bite appliance?			
Do you ever get fever blisters or cold sores?			
Do you have dry mouth?			
Do you drink sodas or sport drinks regularly?			
Do you chew gum, suck on hard candy or cough drops?			
Do you snore?			❑ Don't Know
Does your snoring bother other people?			❑ Don't Know

If you snore, is your snoring:
- ❑ Slightly louder than breathing
- ❑ As loud as talking
- ❑ Louder than talking
- ❑ Louder than talking, can be heard in adjacent room

How often do you snore? ❑ Nearly every day
- ❑ 3-4 times/week ❑ 1-2 times/week
- ❑ 1-2 times/month ❑ Never or nearly never

Has anyone notice that you quit breathing in your sleep? ❑ Nearly every day
- ❑ 3-4 times a week ❑ 1-2 times a month
- ❑ 1-2 times a week ❑ Never or nearly never

Have you ever been diagnosed with sleep apnea?
❑ Yes ❑ No

If so, do you wear a CPAP? ❑ Yes ❑ No

Instructions: Use the scale below to choose the most appropriate number for each situation.
0=would NEVER doze | 1=SLIGHT chance of dozing | 2=MODERATE chance of dozing | 3=HIGH chance of dozing

	Chance of Dozing
Sitting and reading	0 1 2 3
Watching TV	0 1 2 3
Sitting inactive in a public place	0 1 2 3
As a passenger in a car for an hour	0 1 2 3
Laying down in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (no alcohol)	0 1 2 3
In a car and stopped for a few minutes	0 1 2 3
Total Score	*(Add up the Numbers)* _____ / 24

What is the most important thing to you about your dental visit today? _____

Why did you leave your previous dentist? _____

Please rank the following in the order in which they would keep you from accepting dental treatment:

____ Fear of pain # ____ Cost of treatment #____ Lack of concern #____ Convenience

_____ _____ _____ _____

Patient's Signature (Guardian) Date Reviewed By (Signature) Date

Informed Consent for General Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with an accurate medical history before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome. Your mouth truly is connected to your health. The patient is an important part of the treatment team. It is important to report any problems or complications you are experiencing so they can be addressed by your dentist. It is equally important to report your medical conditions to us. Certain heart conditions may create a risk of serious or fatal complications. If you have a heart condition or heart murmur, high blood pressure, diabetes, pregnancy, or other health conditions, advise your dentist immediately so she/he can consult with physician if necessary.

Please inform us of all medication you are currently taking on top of any medications that you are allergic to. If you are taking oral birth control medication, you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes or if you are taking antibiotics.

As with all procedures and surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee you the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally. There are risk and limitations to all procedures. The practice of dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections.

Some of the more commonly known risks and complications of treatment include, but are not limited to, the following:

1.) Pain, swelling, and discomfort after treatment;

2.) Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist;

3.) Temporary, or, on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums and tongue along with possible loss of taste;

4.) Damage to adjacent teeth, restorations or gums;

5.) An altered bite in need of adjustment;

6.) Possible deterioration of your condition which may result in tooth loss;

7.) Jaw fracture;

8.) Allergic reaction to anesthetic or medication;

9.) A root tip, bone fragment or a piece of a dental instrument may be left in your body, and may have to be removed at a later point in time;

10.) If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment;

11.) Infection in need of medication, follow-up procedures or other treatment;

12.) The need for replacement of restorations, implants or other appliances in the future;

13.) Need for follow-up care and treatment, including surgery;

14.) Prolonged numbness.

Specific Problem Examinations

In the event that a patient requests only a specific problem be addressed (i.e. broken tooth, pain in one area, etc.) this is considered a problem-focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. The dentist cannot diagnose problems in other areas of the mouth. Any future treatment of other areas will require additional x-rays and a complete exam. You will not be considered a patient of record unless this examination is completed.

Radiographs (X-Rays)

Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Modern dental x-ray equipment is extremely low dose radiation. Patient will receive a series of intra-oral x-rays. Diagnostic x-rays provide the dentists with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Without these x-rays, we cannot do a complete exam. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.

Minor

We must receive written consent prior to performing any non-emergency procedures on a minor. Grandparents, step-parents, friends, relatives, etc. are not legally allowed to consent to dental procedures. Unless they have been given written consent by the patient or legal guardian, please do not send your child to an appointment alone or with someone else other than yourself unless you have filled out any necessary consent forms prior to the appointment. Otherwise, we may have no choice but to reschedule your child's appointment to another day.

I certify that I read and write English and fully understand this consent. PLEASE ASK THE DOCTOR IF YOU HAVE ANY QUESTIONS CONCERNING THIS CONSENT FORM BEFORE SIGNING IT. By signing this form, I am freely giving my consent to allow and authorize the doctor and/or his/her associates to render any treatment deemed necessary, desirable and/or advisable to me, including the administration and/or prescribing of any anesthetic and/or medication.

Print Patient's Name	Patient's Signature (Guardian)	Date

Print Name (if signed on behalf of the patient)	Relationship

FINANCIAL POLICY AND CONSENT FOR SERVICES

Thank you for choosing Wellwood Family Dentistry, LLC for your dental care. Our team is committed to your overall health and the success of your treatment. Please understand that payment of your bill is considered a part of your commitment to treatment.

Just as we are committed to providing you with the very best dentistry has to offer, so are we committed to making dentistry financially comfortable for you. As a condition of treatment, written financial arrangements are made in advance to ensure you understand your financial obligation. For your convenience, we accept cash, credit cards, debit cards and flex spending cards. We also have flexible payment and dental savings plans available.

INSURANCE: For those patients with dental insurance, we're happy to submit your dental claims and accept payment from your insurance company. Your insurance contract exists solely between you and your insurance carrier. We cannot be responsible for the limitations and exclusion determined by your participating insurance plan. If your insurance carrier downgrades your services or pays a lesser amount according to your coverage then you, the patient will be responsible for the remaining balance due within thirty (30) days of receiving your explanation of benefits from your insurance provider.

TREATMENT PLANS: A treatment plan estimate is a good faith attempt to predict the cost of treatment. As treatment progresses, your dentist may determine in consultation that different or additional treatment is necessary and your financial responsibility may change. Treatment estimates can only be extended for a period of six (6) months from the date treatment was recommended.

AUTHORIZATIONS

☐ **By checking this box:**

- I authorize Wellwood Family Dentistry, LLC to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.
- I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Wellwood Family Dentistry, LLC.
- I grant permission to Wellwood Family Dentistry, LLC to: *(check all that apply)* ☐telephone ☐email ☐text me to discuss my account or treatment.
- I understand that cancellations must be at least 24-hours in advance of a scheduled appointment. The charge for single missed appointments or appointments not cancelled within 24-hours will be charged at a rate of $35 for each missed appointment.
- I understand that interest of 5.25% per month will be added on unpaid balances over sixty (60) days; accounts over ninety (90) days delinquent will be sent to a collection agency and a collection fee of 35% of the balance will be charged to my account; a $35 charge will be added to my account for a returned check.
- I understand that it's my responsibility to notify my dentist within thirty (30) days of service if there is a problem. I also understand the through this notification, my dentist will act on my behalf to attempt to correct the problem or provide a referral to another health care practitioner. Any concerns past thirty (30) days will be the responsibility of the patient and any services provided will be an additional cost to the patient.
- I accept and agree that there are risk and limitations to all procedures. I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee and/or assurance has been made by anyone regarding dental treatment that I have requested and authorized.

I CERTIFY THAT I HAVE READ AND I UNDERSTAND THE ABOVE INFORMATION. I acknowledge that all my questions have been answered to my satisfaction. You have the right to accept or deny treatment before it is performed. The fee(s) for these services have been explained to me and I accept them as satisfactory. I understand the insurance estimate is not a guarantee of payment and that I am responsible for any difference in payment. By signing this form, I am freely giving my consent to authorize Wellwood Family Dentistry, LLC including the dentists, hygienists, and administration to use and/or prescribe anesthetic agents and/or medications. Wellwood Family Dentistry, LLC reserves the right to change or cancel these terms and conditions at any time.

Patient Printed Name	Signature of Patient (Parent or Guardian)	Date
Witness Signature	Date	

Wellwood Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, hereby certify that I have read the Notice of Privacy Practices ("Notice"), which is available on the website located at www.wellwoodfamilydentistry.com and at the practice office. I understand that in accordance with the Health Insurance Portability and Accountability Act of 1996 (also known by its acronym, "HIPAA"), I have certain rights to privacy regarding my protected health information.

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

Wellwood Family Dentistry

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices ("Notice") before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact: Our office administrative team
Telephone: (410) 484-3898

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the practice. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

REVOCATION OF CONSENT – SIGN HERE IF YOU NO LONGER WISH TO BE TREATED AT THIS PRACTICE

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____