PATIENT INFORMATION

We are pleased to welcome you to our office. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you.

PERSONAL

Name: _____
Last First MI (Preferred)

Birthdate: _____ SS #: _____ Gender: ☐ M ☐ F Married: ☐ Y ☐ N

Work Phone: _____ Wireless Phone: _____

Email: _____

Preferred Contact Method: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Preferred Contact Method for Confirmations: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Preferred Contact Method for Recall: ☐ HmPhone ☐ WkPhone ☐ WirelessPh ☐ Email ☐ TextMessage

Student status if dependent over 19 (for ins): ☐ Nonstudent ☐ Fulltime ☐ Parttime

How did you hear about us?

_____

(If someone referred you here, please enter their name so we can thank them.)

ADDRESS AND HOME PHONE

Check box if same for entire family: ☒

Address: _____

Address 2: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

INSURANCE POLICY 1

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Please present insurance card to receptionist.

INSURANCE POLICY 2

Your Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Subscriber Name: _____ Subscriber ID #: _____

Insurance Company: _____ Phone: _____

Employer: _____ Group Name: _____ Group #: _____

Medical History

Last Name: First Name: Birthdate:

Name of Medical Doctor: _____ City/State: _____

Emergency Contact _____ Phone _____ Relationship _____

List all medications or drugs you are now taking:

List all medications or drugs you are allergic to:

List any medical conditions you may have including: asthma, bleeding problems, cancer, diabetes, heart murmur, heart trouble, high blood pressure, joint replacement, kidney disease, liver disease, pregnancy, psychiatric treatment, sinus trouble, stroke, ulcers, or history of rheumatic fever or of taking fen-phen:

Tobacco use? If so, what kind and how much? _____

Unusual reaction to dental injections? _____

Reason for today's visit _____ Are you in pain? _____

New patients:

Do you have a Panoramic x-ray or Full Mouth x-rays that are less than 5 years old? _____

Do you have BiteWing x-rays that are less than 1 year old? _____

Name of former dentist _____ City/State _____

Date of last cleaning and exam _____

Date: 04/27/2023

Dental Patient Screening Form

Patient Name: (First) _____ (Last) _____ **Birthdate:** _____

	Pre-Appointment Self-Assessment Date:	**OFFICE USE ONLY** Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? **Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.**	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

Financial Agreement

Last Name: First Name: Birthdate:

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
* Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
* I agree to pay finance charges of 1.5% per month (18% APR) on any balance 90 days past due.
* I will pay a fee for appointments broken without 24 hours notice.
* Treatment plans may change, and I will be responsible for the work actually done.

I agree to let this office run a credit report. If no, then all fees are due at time of service.

☐ Yes
☐ No

Signature: _____ Date: 04/27/2023

Notice of Privacy Policies

Last Name: First Name: Birthdate:

I have had full opportunity to read and consider the contents of the Notice of Privacy Practices. I understand that I am giving my permission to your use and disclosure of my protected health information in order to carry out treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke permission.

Signature:

_____ Date:

CANCELLATION & NO-SHOW POLICY

Our goal at W Dental Group is to provide quality, specialized dental care in a timely manner. We do understand that illness, emergencies and bad weather do occur. We ask our patients to give us 48 hours' notice if they cannot keep an appointment. This allows us time to fill schedule with other patients who may be waiting. We appreciate your understanding and consideration regarding our cancellation and fa appointment policy. Please not the following to be better serve you and other patients:

Cancellation or rescheduling of an appointment with 48 hours or more notification will result in no charge. This does NOT apply if the appointment in question has been moved more than 2 times.

A failed appointment is an appointment that is canceled/rescheduled without 48 hours; notice or an appointment where a patie NOT show up.

Depending on the circumstances, we MAY allow for one (1) broken appointment as a courtesy.

ALL SURGERY APPOINTMENTS - Due to the fact that most surgery requires us to dedicate up to 4 hours of our time, we REQUI (1) WEEK NOTICE FOR CANCELLATIONS. If this is not done, you will lose the entire deposit that you use to reserve t

Failed DENTAL HYGIENE appointments will be charged a fee of $25 w/o 48-hour notice.

Failed DOCTORS APPOINTMENTS will be charged a fee of $50 w/o 48-hour notice.
ALL SURGERIES will charge the entire deposit if ONE WEEK NOTICE IS NOT PROVIDED.
After two (2) failed appointments, we may require a deposit of up to 100% to reserve any further appointments.
After three (3) failed appointments, you risk being dismissed from the practice. Please understand our policy is to val respect YOUR time.

W Dental Group is a private practice dental office and NOT a basic dental "clinic" or a corporate dental "clinic" where they see their pa MASS VOLUME basis.

Appointment time is reserved for you and you alone. Where appropriate, we prefer to schedule longer appointments so we can prope complete as much dental treatment as needed during one appointment. We feel that this type of scheduling will cause minimal disrup YOUR daily schedule and will provide efficiency in completing your dental care. When you make an appointment, please be sure tha be able to keep it. Just note that morning appointments are best for more complicated and more extensive procedures because if ad time is needed to properly provide you with the best dentistry, we will have it. If you are to cancel an appointment, please call the offi number below to speak directly with one of our team members in charge of scheduling 48 hours to 1 week (depending on appt type) befor scheduled appointment to avoid the cancellation fee. If you do not reach a team member, please leave a detailed message on t voicemail and one of our team members will return your call. An alternative method is to email - please utilize the specific email your appointment type below. waxdental@outlook.com

Name:

Signature _____