Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

□ Male □ Female □ Married □ Single □ Child □ Widowed □ Divorced

Birthday: _____ Social Security #: _____ DL#: _____

Address: _____
street apt # city state zip

E-Mail Address: _____

Home #: _____ Work #: _____ ext: _____ Cell/ Other #: _____

Employers Name: _____ Occupation: _____

Spouse Name: _____ Phone: _____

Health Information

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please circle those that apply:

AIDS	Fainting	Pacemaker	Venereal Disease
Allergies_____	Glaucoma	**Pregnancy**	**Codeine Allergy**
_____	Growths	Due date: _____	**Penicillin Allergy**
	Hay Fever	Thyroid	**LATEX Allergy**
Anemia	Head Injuries	Radiation Treatment	
Arthritis	Heart Disease	Respiratory Problems	Are you taking any
Artificial Joints	Heart Murmur	Rheumatic Fever	medications/Vitamins?
Asthma	Hepatitis	Rheumatism	Please list below:
Blood Disease	High Blood Pressure	Sinus Problems	_____
Cancer	Jaundice	Stomach Problems	_____
Diabetes	Kidney Disease	Stroke	_____
Dizziness	Liver Disease	Tuberculosis	_____
Epilepsy	Mental Disorders	Tumors	_____
Excessive Bleeding	Nervous Disorders	Ulcers	_____

Is there anything that is not listed that our office needs to know about medically? _____

_____

Which of the following do you experience?

- Frequent, heavy snoring? □ Yes □ No
- Significant day time sleepiness? □ Yes □ No
- Have you been told you stop breathing while sleeping? □ Yes □ No
- Do you gasp at times when waking up? □ Yes □ No
- Do you feel un-refreshed in the morning? □ Yes □ No
- Do you have morning headaches? □ Yes □ No
- Are you aware of any teeth grinding or clenching at night? □ Yes □ No
- Which of the following do you own?

  1. CPAP? □ Yes □ No how often do you wear it? _____
  when did you start wearing it? _____

  2. Night Guard? □ Yes □ No how often do you wear it? _____
  3. Retainer? □ Yes □ No how often do you wear it? _____

- Have you ever had any complications following dental treatment? □Yes □No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? □ Yes □No
  If yes, please explain: _____
- Are you now under the care of a physician? □ Yes □ No
  If yes, please explain: _____
- Name of physician: _____ Phone: _____
- Do you have any health problems that need further clarification? □ Yes □ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I acknowledge that I have received the Notice of Privacy Practices.

_____

Signature of patient, parent or guardian **Date**

Referral Information

Whom may we thank for referring you to our practice? _____
Name of Person

□ Friend □ Relative □ Yellow Pages □ another Dental Office □ Newspaper □ School □ Work
□ Neighbor to Neighbor □ Internet □ Drive By

Responsible Party Information

Name:_____ Relationship to Patient: _____

Address: _____
Street Apt # City State Zip

DOB: _____ SS: _____ E-Mail Address: _____

Home #:_____Work #: _____ ext:_____ Cell/ Other #: _____

Employers Name: _____Occupation: _____

Insurance Information

Patient's Relationship to Insured: □ Self □ Spouse □ Child

Name of Insured:_____Is insured a patient? □Yes □ No
Last First MI

Insured's Address: _____
Street City State Zip

Insured's Birth Date: _____ Insured's Social Security: _____

Insured's Employer Name: _____

Insured Member ID: _____

Insurance Plan Name and Address: _____

_____

Insurance Phone #:_____Group/Plan #_____

*Please provide our office with a **copy of your dental card** and benefit information to help better serve your dental insurance needs.

Dental Records Transferred

Name of previous dentist_____
Address _____
Phone Number _____
Date of last dental visit_____

Consent for Services & Insurance Disclaimer

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and 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 at the time services are performed.

Insurance Disclaimer:

"A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the member's contract at time of service."

Insurance Liability for Payment:

Your health insurance company will only pay for services that it determines to be "reasonable and necessary." Every effort will be made by this office to have all services and procedures preauthorized over $300, by your dental insurance company. If your dental insurance company determines that a particular service is not reasonable and necessary, or that a particular service is not covered under the plan, your insurer will deny payment for that service.

Beneficiary Agreement:

I understand that my dental insurance company may deny payment for the services identified above, for the reasons stated. If my dental insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my dental insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

We take Visa/MasterCard and Discover and offer Care Credit.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of (6) six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that a waiver of any breach of any time ore 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.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Dr. Wuensch and his staff are fully compliant with all federal and state privacy laws.

No one from this office will discuss your medical/dental condition or treatment with anyone outside of this office without your consent.

I understand that the Health Information Privacy Act (HIPPA) is available for me to read at any time.

_____ _____

Signature of Patient, Parent or Legal Representative Date