Welcome

Wolfchase Family Dentistry

Dr. Joseph Carson

1 About You

Today's Date: ____/____/____ File #: ____

Patient Name ____
LAST FIRST MI

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

____
CITY STATE ZIP

Home Phone #: (____) ____

Work Phone #: (____) ____ Ext. ____

Cell Phone $: (____) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

____
CITY STATE ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

2 Dental Information

Reason for today's visit ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? ____

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw.
❑ Red, swollen or bleeding gums.
❑ Sensitive tooth, teeth or gums.
❑ Blisters/Sores in or around the mouth.
❑ Ringing in Ears.
❑ Broken or Chipped Tooth
❑ Lost/Broken Filling(s)
❑ Stained teeth
❑ Teeth grinding
❑ Locking Jaw
❑ Bad Breath
❑ Other: ____

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____ (____) ____
Name Phone#

Last Dental Exam ____/____/____ Last Dental x-rays: ____/____/____

Times a day you brush? ____ Times a week you floss? ____

What type of tooth brush bristles do you use?
❑ Soft ❑ Medium ❑ Hard

How would you rate your smile?
(Worse) 1 2 3 4 5 6 7 8 9 10 (Best)

3 Account Info

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

____
CITY STATE ZIP

SS# ____

Drivers License #: ____

Work Phone#: ____

Payment method: ❑ Cash ❑ Check

____ ____/____
❑ Credit Card - Enter card # above (if accepted) Exp. Date

Please note: *A broken appointment fee of $35.00 for every 30 minutes of appointment time will apply to your account if less than 24 hours notice.*

Any returned checks will incur a fee of $30.00.

____ I hereby authorized assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).
Initials

4 In event of emergency

Whom should we contact? ____

Relation: ____

Home Phone #: (____) ____

Work Phone #: (____) ____

Cell Phone #: (____) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: (____) ____

PLEASE CONTINUE ON BACK

5 Medical History

Are you taking any of the following medications? ❑ **Nerve Pills** ❑ **Pain Killers (including aspirin)** ❑ **Muscle relaxers** ❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin**

❑ **Other(s), please list:** _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

Yes	No		Yes	No		Yes	No		Yes	No	
❑	❑	Heart Attack / Stroke	❑	❑	Thyroid Problems	❑	❑	Cancer/Tumors	❑	❑	Cosmetic Surgery
❑	❑	Heart Surg./Pacemaker	❑	❑	Kidney Problems	❑	❑	Shingles	❑	❑	Xray or Cobalt Treatment
❑	❑	Heart Murmur	❑	❑	Liver Problems	❑	❑	Hepatitis	❑	❑	Chemotherapy
❑	❑	Rheumatic Fever	❑	❑	Respiratory Problems	❑	❑	HIV+/AIDS/ARC	❑	❑	Asthma
❑	❑	Mitral Valve Prolapse	❑	❑	Sinus Problems	❑	❑	Arthritis/Rheumatism	❑	❑	Difficulty Breathing
❑	❑	Artificial Valves	❑	❑	Stomach Problems/Ulcers	❑	❑	Artificial Bones/Joints	❑	❑	Diabetes/Hypoglycemia
❑	❑	Heart Disease	❑	❑	Psychiatric Problems	❑	❑	Emphysema	❑	❑	Leukemia
❑	❑	Congenital Heart Defect	❑	❑	Venereal Disease	❑	❑	Fainting/Seizures/Epilepsy	❑	❑	Anemia
❑	❑	Chest Pains	❑	❑	Alcohol/Drug Abuse	❑	❑	Severe/Frequent Headaches	❑	❑	High/Low Blood Pressure
❑	❑	Scarlet Fever	❑	❑	Tuberculosis TB	❑	❑	Frequent Neck Pain	❑	❑	Bleeding Problems
❑	❑	Nervousness	❑	❑	Jaw Problems TMJ/TMD	❑	❑	Back Problems	❑	❑	Glaucoma

Please list any other surgeries or medical conditions you have or ever had: _____

_____

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin ❑ Dental Anesthetics

❑ Others: _____

Do you use tobacco? ❑ No ❑ Yes/How Used? _____ How much? _____ How long? _____

Please rate your general health from 1–10: _____ Do you wear contact lenses? ❑ Yes ❑ No

Have you ever taken the drug Phen-fen and/or Redux? ❑ Yes ❑ No **For women:** Are you taking Birth Control pills? ❑ Yes ❑ No

Are you Pregnant? ❑ No ❑ Yes/How long? _____ Are you nursing? ❑ Yes ❑ No

6 Insurance Info

Primary Dental Insurance

Co. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____ Insured's SS# _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

City _____ State _____ Zip _____

Phone #: _____ Insured's SS# _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Employer: _____

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account. Any returned check is subject to a fee of $30.00 as stated elsewhere on this form. A broken appointment fee will be assessed at a rate of $35.00 for each 30 minutes of scheduled appointment time if less than 24 hours notice.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ___/___/___

❑ Adult Patient ❑ Parent or Guardian ❑ Spouse

UPDATE
(OFFICE USE)

Initials ___ Date ___/___/___

Comment _____

Initials ___ Date ___/___/___

Comment _____

Initials ___ Date ___/___/___

Comment _____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to-day healthcare operations of your practice.**

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20___.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

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