PATIENT INFORMATION

Name: Last _____ First _____ MI _____

Preferred Name: _____ Preferred Pronoun: He/Him She/Her Decline to answer Other: _____

Address: _____ City _____ State _____ Zip _____

Phone Number: Home _____ Work _____ Cell _____

Birthdate: _____S.S.# _____ Email _____

Responsible Party (Parent/Guardian) Information ☐ **check here if same as above.**

Name: Last_____ First_____ MI ___ Birthdate_____

Address: _____City _____ State _____ Zip _____

Phone Number: Home _____ Work _____ Cell _____

Emergency Contact Information

Name: _____ Phone: _____

INSURANCE INFORMATION

Policyholder's Name: Last _____ First _____ MI _____

Birthdate: _____ S.S.# _____ Employer: _____

Insurance Company Name/Claim Address: _____

Group Number: _____ID Number: _____

SECONDARY INSURANCE (If applicable)

Policyholder's Name: Last _____First _____ MI _____

Birthdate: _____ S.S.# _____ Employer: _____

Insurance Company Name/Claim Address: _____

Group Number: _____ ID Number: _____

CONSENT: I consent to the necessary treatment recommended by the dentist for dental care and for the dentist to use and disclose my records (child records) to perform treatment. I consent to the release of my records (child records) to individuals involved in my care (child's care) or payment of that care. My consent to the disclosure of my records (child records) shall be effective until I terminate it in writing. I understand that my dental insurance carrier may not pay the full amount of the actual bill for service completed and that I am responsible for payment in full of all accounts. By signing this I agree to be responsible to pay for services completed and not paid for by my dental care payer. I consent that the information on this form is accurate and current.

Patient/Guardian Signature: _____ **Date:** _____

Relationship to Patient: _____

DENTAL HISTORY

What is the current Condition of your mouth? Good Fair Poor

How often do you brush your teeth per day? Rarely 1x/day 2x/day **Electric Toothbrush?** Y N

How often do you floss your teeth per day? Rarely Daily

Is your home water supply fluoridated? Yes No DK

Do you have sores or ulcers in your mouth Yes No DK

Do you wear partials? Yes No DK

Have you ever had a serious injury to your head or mouth? Yes No DK

Date of your last dental exam: _____

Do you have any of the dental concerns listed below?

Gum disease	Yes	No	**Crooked/crowded teeth**	Yes	No
Bleeding gums	Yes	No	**TMJ/clicking/popping in jaw**	Yes	No
Gum sensitivity	Yes	No	**Breathe Malodor**	Yes	No
Food catches between teeth	Yes	No	**Snoring/sleep apnea**	Yes	No
Tooth sensitivity	Yes	No	**Untreated Problems**	Yes	No
Loose Teeth	Yes	No	**Grinding or clenching your teeth**	Yes	No

Other (please explain): _____

Any previous bad dental experiences or fears: _____

Cosmetic Assessment

Would you like your smile to look better or different? Yes No

Do you have discolored teeth that bother you? Yes No

Have you ever worn braces on your teeth? Yes No

CANCELLATION/FAILED APPOINTMENTS POLICY

Our office policy requires that you notify us of any changes in plans 48 hours prior to your reserved appointment(s). This permits another patient to receive dental care in your absence. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. Patients who fail to show or do not cancel 48 hours in advance will be subjected to a $50 fee. I have read and understand the information provided above.

Print Name of Patient/Guardian: _____ **Date: _____**

SIGNATURE: _____

MEDICAL HISTORY

Are you under the care of a medical professional? Yes No **Date of last physical:** _____

Physicians name: _____ **Phone:** _____ **Clinic:** _____

Are you currently taking any medications? Yes No

(List medications here) _____

Have you ever been told to take antibiotics prior to dental treatment? **Yes** **No**

Joint Replacement	Yes	No	**Approximate Date:** _____
Prosthetic Cardiac Valves	Yes	No	
Prosthetic Valve Repair	Yes	No	
Infective Endocarditis	Yes	No	
Heart Transplant	Yes	No	
Congenital Heart Defect	Yes	No	

Have you ever taken any form of bisphosphonates (e.g. Aredia, Zometa,XGEVA)? **Yes** **No**

Have you ever taken drugs for osteoporosis or bone disorder (e.g. Fosamax, Actonel)? **Yes** **No**

Are you currently taking any blood thinners (anticoagulants)? **Yes** **No**

Do you have any allergies or sensitivities?

Penicillin	Yes	No	**Aspirin**	Yes	No
Local Anesthetic	Yes	No	**Erythromycin**	Yes	No
Sulfa	Yes	No	**Latex**	Yes	no
Nitrous Oxide	Yes	No	**Other (please list)** _____		
Codeine	Yes	No			

Do you currently have, or have you ever had any of the following?

Heart problems/surgery	Yes	No	**Heart murmur**	Yes	No
Pacemaker	Yes	No	**Abnormal bleeding**	Yes	No
Diabetes	Yes	No	**Blood disorders**	Yes	No
Abnormal blood pressure	Yes	No	**Asthma**	Yes	No
Thyroid problems	Yes	No	**Cancer**	Yes	No
Hepatitis, Jaundice or liver disease	Yes	No	**Ulcers**	Yes	No
Stroke	Yes	No	**Sinus problems**	Yes	No
HIV/AIDS	Yes	No	**Rheumatic heart disease**	Yes	No
Lung Disease(s)	Yes	No	**Used Fen-Phen or Redux**	Yes	No
Mental Health Disorders	Yes	No	**Autoimmune disease**	Yes	No
Emphysema	Yes	No	**Tuberculosis**	Yes	No
Epilepsy	Yes	No	**Anemia**	Yes	No
Eating Disorder	Yes	No	**Gastrointestinal Disease**	Yes	No
Osteoporosis	Yes	No	**Excessive Urination**	Yes	No
Sleep Disorder	Yes	No	**Neurological disorders**	Yes	No

Do you use tobacco? Yes No

What type? _____

<u>WOMEN ONLY:</u> Are you pregnant? Yes No

Number of weeks: _____ **Taking birth control or hormonal replacement** **Yes** **No**

Nursing? **Yes** **No**

Any other past/present health problems, hospitalizations or illnesses not listed? Yes No

<u>Please explain</u>: _____

Signature: _____ **Date:** _____

By signing below, I certify that the information above is accurate and complete to the best of my knowledge.

PAYMENT AGREEMENT

In exchange for services rendered by Woodbury Family Dentists (WFD)

1. **My responsibilities**. I understand that insurance is estimated, and the actual coverage may be less than estimated. I, the patient (or responsible party if patient is a minor), am responsible for payment of all amounts not covered by my insurance carrier, regardless of the estimate, I also understand that it is my own responsibility to know or to determine what my insurance plan covers or does not cover, including deductibles and yearly/lifetime maximum amounts.

2. **Payment Due at Time of Service**. Unless, at the time of receiving dental services, I present evidence of dental insurance currently in effect. I understand that payment is due in full at the time of service, unless other arrangements are made in advance. WFD offers a 5% discount for payment made with check or cash the date of service.

3. **90 Day Payment Terms**. If I cannot pay at the time of service and if I arrange in advance to be billed for services performed, I understand that WFD offers payment at no interest for up to 90 days. The balance must be paid in full within 90 days by cash, check, credit card or CareCredit financing.

4. **Referral to Collections**. After 90 days, outstanding balances of any amount will be turned over for collections pursuant to the laws of the State of Minnesota. I agree to pay all reasonable attorney fees, disbursements, and collection fees incurred by WFD in an effort to collect past due payments on my account.

5. **Option to Use CareCredit**. In any two circumstances, (1) If I cannot pay at the time of service: or (2) if I have made arrangements to pay within 90 days but cannot do so, I understand that I also have the option to pay through CareCredit, an independent organization that will pay WFD in full and that may provide me with a small, extended monthly payments. I may obtain information about CareCredit directly. I am responsible for working with CareCredit to obtain credit through that organization.

6. **My Consent**. I hereby understand that failure to sign this Payment Agreement does not negate my financial responsibilities to pay for any services that have been rendered: By accenting dental services or treatment, of any type, I am giving my consent to the terms as outlined in this Payment Agreement.

7. **My understanding of These Terms**. I have read, understand, and agree with all of the above. I also understand that I may have a full accounting of all payments to my account simply by asking.

8. **Written Modifications Only**. This Agreement may not be modified except in writing signed by WFD

✕ Patient Signature: _____ **Date:** _____

Parent (or responsible party): _____ **Relationship to Patient:** _____

CONSENT FOR USE AND DISCLOSE OF HEALTH INFORMATION (HIPAA)

PLEASE READ THE FOLLOWING STATEMENTS

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 and activities, and healthcare operations. Notice of Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully before signing this consent. We reserve the right to change our privacy practice 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, include any revisions of our notice, at any time by contacting us at: (651) 731-8424

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

✕ Signature: _____ **Date:** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Representative's Name: _____**Relationship to patien**t: _____

Request for designated others to have access to Account Information

I, _____ authorize Woodbury Family Dentists to disclose my account information regarding scheduling and billing information to the following designated people:

Print Full Name _____ Relationship _____ Phone Number _____