

How did you hear about our office?

- | | |
|--|--|
| <input type="checkbox"/> Friend/Relative | <input type="checkbox"/> Computer Search |
| <input type="checkbox"/> Current Webster Patient | <input type="checkbox"/> Mailing |
| <input type="checkbox"/> Dental Insurance | <input type="checkbox"/> Social Media Site _____ |

Who may we thank for referring you to our office? _____

DENTAL HISTORY:

Reason for today's visit?

Date of last dental visit? _____ Did you bring x-rays? YES NO

Why did you decide to change dental offices?

Is there anything in your mouth or about your smile that you would like to change or modify? YES NO
If yes, please specify:

How do you rate your dental health? Good Fair Bad

Do your gums bleed when you brush or floss? Yes No

Do you own an electric toothbrush? Yes No

Do you smoke or use chew tobacco? Yes No

Please check if you have or do any of the following:

- | | | |
|--|--|---|
| <input type="checkbox"/> Bad Breath | <input type="checkbox"/> Sensitivity to Biting | <input type="checkbox"/> Dry Mouth |
| <input type="checkbox"/> Blisters on Lips/Mouth | <input type="checkbox"/> Sensitivity to Sweets | <input type="checkbox"/> Missing Teeth |
| <input type="checkbox"/> Clicking/Popping of Jaw | <input type="checkbox"/> Sensitivity to Hot/Cold | <input type="checkbox"/> Sores or Growths in your Mouth |
| <input type="checkbox"/> Clenching of Teeth | <input type="checkbox"/> Jaw Pain | <input type="checkbox"/> Mouth Breather |
| <input type="checkbox"/> Grind Teeth | <input type="checkbox"/> Ear Pain | <input type="checkbox"/> Suck Your Thumb |
| <input type="checkbox"/> Broken/Loose Teeth or Filling | <input type="checkbox"/> Headaches | <input type="checkbox"/> Food Collecting Between Teeth |

Have you been treated for any of the following?

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Periodontal Disease | <input type="checkbox"/> Sleep Apnea or Snoring |
|---------------------------------------|--|---|

Are you afraid of the dentist or have you had a bad experience? Yes No

Do you have any allergies or have you had any bad reactions to:

- Local Anesthetic
- Antibiotics _____
- Latex
- Other _____

MEDICAL HISTORY:

Are you under physician's care? Yes No If yes, for what? _____

Physician's name: _____ Physician's #: _____

Please list medications and other pills you are taking:

Do you generally take antibiotics before a dental visit? Yes No

Please check any and all that you have had: (indicate date if possible)

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Radiation | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Shingles | <input type="checkbox"/> Artificial Joints |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Psychiatric Issues | <input type="checkbox"/> Chemotherapy | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> HIV/Aids |
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Epilepsy and Seizures |
| <input type="checkbox"/> Major Surgery | <input type="checkbox"/> Fainting or Dizziness | <input type="checkbox"/> Bleeding/Clotting | |

Are there any other medical issues or conditions not listed that we should know about?

Females: Are you pregnant or trying to get pregnant? Yes No Are you nursing? Yes No
Are you on birth control pills? Yes No

Please certify that the above information is complete and accurate. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the office of any changes in medical status.

Signature of patient or guardian: _____ Date: _____

CONSENT FOR TREATMENT:

- I hereby authorize Doctor or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed necessary to make a thorough diagnosis of _____'s dental needs. NAME OF PATIENT
- Upon such diagnosis, I authorize the Doctor and/or Hygienist to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I am aware that this office provides optimal care as recommended by the ADA and my dental insurance may not cover certain procedures. It is my responsibility to be aware of what is covered by my insurance.
- I agree to the use of anesthetics and other medications as necessary. I fully understand that the use of said agents imposes certain risks and realize that it is necessary to inform the doctor and staff of any drugs, including recreational drugs that I may be taking in order to minimize these risks.
- A fee of \$1.00 per minute of appointment time will be charged if an appointment is cancelled without 24 hours notice.

Patient or Guardian (Printed): _____

Signature of Patient or Guardian: _____ Date: _____

FINANCIAL AND OTHER POLICIES:

I understand that payments for all services are to be paid at the time of service unless different payment arrangements are made in advance. We will work with you if we have confirmed dental insurance and collect only the **estimated** copayment at the time of service. We make no guarantee that the amount we collect is accurate. We estimate the collected copayment from historical data. If you want a more accurate estimate, ask to have a **pretreatment estimate** to your insurance company. We will gladly submit your insurance claim to the insurance address you gave us. If we do not get paid within 30 days of submission of the claim we will look to you for full payment of your bill. Once we reach your annual maximum benefit, we will look to you for complete payment at the time of service unless a written payment plan has been made. We accept cash, checks, money orders and all major credit cards for your payments.

Assignment of Benefits: I hereby authorize my insurance company to pay directly to Webster Dental Care benefits accruing to me under my policy. A service charge of 1.5% per month (18% per annum), but in no event more than the maximum rate permissible under state laws will be charged on the unpaid principle balance on all accounts not paid within 60 days of the treatment date. I further understand the fee estimates listed for my dental care can only be extended for a period of six months from the date the estimate was written.

After 90 days from the date of service any unpaid accounts will be referred to a collection agency. I will then be responsible for my balance plus an additional 30% of the unpaid balance as the agency fee and any attorney's fees. I grant my permission to you, or your assigns to telephone me at my home or place of employment to discuss matters related to this form, my treatment or billing issues.

I understand that there is a \$1.00 per minute of appointment time charged for appointments cancelled with less than 24 hours notice.

Please silence your cell phones when in the treatment rooms.

Warning: Do not sign this if you have any questions about the financial policies of our offices. If you have any questions, ask one of our financial coordinators before signing this paper.

In accordance with HIPAA, I agree to the disclosure of my protected health information to my insurance company. I authorize my insurance company to pay Webster Dental directly.
I have read the above Financial and Other Policies and agree to the content.

Signed: _____ Date: _____

Webster Dental Care Acknowledgement of Receipt of Notice of Privacy Practice:
(Please notify clerk if you refuse to sign this Acknowledgement)

I, _____ have received a copy of the office's Notice of Privacy Practice.

Printed Name: _____

Signature: _____ Date: _____