WELDON DENTAL

Patient Name: _____ Date of Birth: _____
(Last) (First) (MI) (Preferred Name)

Sex: ❑Male ❑Female Marital Status: ❑Married ❑Single ❑Child ❑Other: _____

Social Security #: _____ Address: _____
Street Apt #

City: _____ State: _____ Zip Code: _____

Preferred Phone Number: _____ Is this a cell phone? ❑Yes ❑No

Are text messages ok? ❑Yes ❑No Email Address: _____

Additional Contact Person (not listed above):

Name: _____ Phone: _____ Relation: _____

Health History

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

❑Acid Reflux	❑Dialysis	❑Liver Disease	ALLERGIES
❑ADD/ADHD	❑Dizziness/Fainting	❑Mental Disorders	❑Amoxicillin Allergy
❑Allergies/Sinus Problems	❑Dry Mouth	❑Nervous Disorders	❑Codeine Allergy
❑Alzheimer's/Dementia	❑Epilepsy/Seizures	❑Osteoporosis	❑Erythromycin Allergy
❑Anemia	❑Excessive Bleeding	❑Radiation Treatment	❑Latex Allergy
❑Anxiety	❑Glaucoma	❑Respiratory Problems	❑NSAIDs Allergy
❑Arthritis	❑Headaches/Migraines	❑Rheumatic Fever	❑Penicillin Allergy
❑Asthma	❑Head Injuries	❑Recent Surgeries	❑Sulfa Drug Allergy
❑Autism	❑Heart Condition	❑Stomach Problems	Other Allergies or
❑Blood Disease	❑Heart Murmur/MVP	❑Stents	Conditions:
❑Cancer/Leukemia	❑Hepatitis TYPE: ___	❑Stroke	
❑Cold Sores/HSVI	❑High Blood Pressure	❑Thyroid Disease	
❑Deaf/Hearing Impaired	❑Joint Replacement	❑Tobacco Use	
❑Diabetes TYPE: _____	❑Kidney Disease	❑Ulcers	

- If you indicated "Recent Surgeries" (within the last two years) or "Joint Replacement" above, please list the date and procedure completed:_____
- Do you take any blood thinner/anti-coagulant or bisphosphonate medications? ❑Yes ❑No If yes, please list:_____
- Please list any medications or herbal supplements you are currently taking (or provide a list if need be):
  _____
- Name of your family doctor: _____ Are you under the care of a specialist? ❑Yes ❑No
- Please check any conditions that apply: ❑Toothache ❑Jaw Pain (TMJ) ❑Dental Implants
  ❑Teeth Grinding/Clenching ❑Swollen/Bleeding Gums ❑Broken/Loose Teeth

Women: Are you currently pregnant? ❑No ❑Yes Estimated Delivery Date: _____ Dr: _____

Are you nursing? ❑No ❑Yes *Please note if you are taking any birth control prescriptions, antibiotics may alter the effectiveness of birth control pills.

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 doctor at future appointments.

Signature: _____ Date: _____

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Responsible Party

Relationship to Patient: ❑SELF or ❑Patient's Parent/Guardian (if patient is a minor)

Please complete the following if the responsible party is not the patient:

The patient receiving service is the responsible party. If the patient is a minor, then the parent or legal guardian information is to be used. This person is to receive financial information regarding services rendered and outstanding balances owed by monthly statements that will be mailed.

Name: _____ Date of Birth: _____ Relationship: _____

Sex: ❑Male ❑Female Marital Status: ❑ Married ❑Single ❑Other: _____

Social Security #: _____ Contact Phone #: _____

Signature of RESPONSIBLE PARTY: _____ Date: _____

Employment Information

Employer Name: _____ Occupation: _____

Address: _____

Street City State Zip Code

Authorization: In the event I cannot be reached, am not present in the office, or **if patient is a minor,** I authorize the following individuals **(including spouse/parents/family)** permission to discuss:

❑Scheduling Appointments ❑Financial Arrangements ❑Consent to Treatment ❑Completed Services

NAME(S): _____

Insurance Information

Insurance Carrier Name: _____ Insurance Phone Number: _____

Dental Claims Mailing Address: _____

Employer/Group Name: _____ Group #: _____

Is the subscriber the same person as the patient? ❑Yes ❑No

If no, please fill in the following information for the policyholder:

Subscriber Information:

First Name: _____ Middle Name: _____ Last Name: _____

Date of Birth: _____Social Security #:_____ Member ID #:_____

Patient Relationship to Subscriber: ❑Spouse ❑Child

Release of Information to Insurers and Assignment of Benefits (must be signed by all patients with insurance and those who expect to obtain insurance) To the extent permitted by law, I give consent to Weldon Dental to use and disclose my Protected Health Information to carry out payment activities in connection with my insurance claims. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to Weldon Dental for the dental benefits otherwise payable to me.

Signature: _____ **Date:** _____

WELDON DENTAL

Who may we thank for referring you? _____

- Consent for Services - Responsibility of Payment -

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred during their care. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services received. This office will help prepare the patient's insurance forms and assist in making collections from insurance companies and will credit any such collections to the patient's account as a courtesy. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies deny any guarantee of the accuracy of the information shared regarding available benefits or estimated covered allowances. Final determination of benefits are determined once a claim is processed. Any payments collected in the office at the time of services are based on *estimates only.* Any treatment not covered by insurance is patient responsibility to pay. I understand that the fee estimate listed for dental care can only be extended for a period of up to six months from the date of the patient examination.

In consideration for the professional services rendered to me, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered. I further agree to pay all costs and reasonable attorney fees if suit were filed for services rendered.

I understand my obligation to keep in contact with the office regarding changing a scheduled appointment I have arranged, for services to be completed. By failing to provide adequate notice (less than 24 hours) I understand I may be inhibiting the doctor's ability to provide care to others who may be in need of dental care also by failing to present for the reserved appointment scheduled.

I grant my permission to you or your assignee, to contact me at home or at my other listed phone numbers to discuss matters related to this form. As a courtesy, Weldon Dental will allow payments for balances owed to be paid by phone with no additional fee. My signature allows transactions for given credit card information at the time of each transaction by phone, and otherwise will require a separate credit card agreement for additional reoccurring payments.

Signature: _____ Date: _____

(If patient is a minor or disabled the parent, legal guardian or Attorney-in-Fact must sign and complete the Responsible Party section as well).

- Notice of Privacy Practices -

Notice of Privacy Practices (must be signed by ALL patients)

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPPA").

Signature: _____ Date: _____

(If patient is a minor or disabled the parent, legal guardian or Attorney-in-Fact must sign and complete the Responsible Party section as well).