PATIENT REGISTRATION

Patient's Name: _____
(First) (Middle Initial) (Last)

Address: _____ **Address 2:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Ext:** _____ **Cellular:** _____ **Pager:** _____

Patient's Sex: ___Male ___Female **Marital Status:** ___Married ___Single ___Divorced ___Separated ___Widowed

Patient's Birth date: _____ **Social Security Number:** _____

If patient is over age 18 and a student, student status: _____Full time _____ Part time **Name of school and location:**_____

I would like to receive appointment reminders via e-mail: yes or no Email:_____

Responsible Party (if someone other than the patient is responsible for the bill)

Responsible Party's Name: _____
(First) (Middle Initial) (Last)

Address: _____ **Address 2:** _____

City: _____ **State:** _____ **Zip:** _____

Home Phone: _____ **Work Phone:** _____ **Ext:** _____ **Cellular:** _____ **Pager:** _____

Responsible Party's Birth date: _____ **Social Security Number:** _____

___Responsible Party is also a Policy Holder for Patient ___Primary Insurance Holder ___Secondary Policy Holder

Primary Insurance Information

Name of Insured: _____ **Relationship to patient:** ____Self ____Spouse ___Parent ___Other

Insured Social Security or Member Identification Number (if not SS #): _____ **Insured DOB:** _____

Employer: _____

Insurance Company: _____ **Telephone:** _____

Address: _____ **Address 2:** _____

City, State, Zip: _____

Secondary Insurance Information

Name of Insured: _____ **Relationship to patient:** ____Self ____Spouse ___Parent ___Other

Insured Social Security or Member Identification Number (if not SS #): _____ **Insured DOB:** _____

Employer: _____

Insurance Company: _____ **Telephone:** _____

Address: _____ **Address 2:** _____

City, State, Zip: _____

In case of emergency is there someone we may contact _____

Telephone #_____ **Relationship to you**_____

After completing the front portion of this form, please review and sign our financial policy on the back.

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

_____

_____

_____

_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Wolken

Providing Family and Cosmetic Dentistry with Personal Care

Dental Health Questions

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle, yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Patient's Name:_____ Date of Birth:_____

How did you hear about our practice? Friend or Family Member (name)_____

Insurance Directory Advertisement Other_____

1. Are you having any discomfort at this time? yes no

2. Date of your last dental visit_____
3. Have you been treated for periodontal disease? yes no
4. Do you have or have you ever had any of the following?

Bleeding, sore gums	yes	no
Unpleasant taste/bad breath	yes	no
Burning tongue/lips	yes	no
Frequent blisters lips/mouth	yes	no
Swelling/lumps in mouth	yes	no
Ortho treatments (braces)	yes	no
Biting cheeks/lips	yes	no
Clicking/popping jaw	yes	no
Difficulty opening or closing jaw	yes	no
Loose teeth	yes	no
Sensitive to hot or cold	yes	no
Sensitive to sweets	yes	no
Food impaction	yes	no
Grinding/clenching	yes	no
Shifting or change in bite	yes	no

5. Do you use the following?

Toothbrush yes no How Often?_____

Dental floss yes no How Often?_____

NOTICE OF PRIVACY PRACTICES
PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my medical treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I contact this organization at any time at the below address to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name:_____Date:_____

Signature:_____Relationship to Patient:_____

PERMISSION TO LEAVE A MESSAGE

Due to HIPAA regulations, we are not permitted to leave a message regarding your appointments without prior permission from you. You need to give us verbal permission which only then we can document in your account. If you do not provide permission then you will receive a phone call requesting that you contact Dr. Wolken's office.

This permission will only be used to leave messages for appointments, no other message will be left nor any information given to anyone without written permission from you.

Name:_____Date:_____

Signature:_____

WOLKEN DENTAL FINANCIAL POLICY

It is the patient's responsibility to provide our office with the correct billing and insurance information. This includes name, date of birth, social security number, place of employment, name of employee carrying insurance; as well as the name and address of the insurance company. Failure to provide the correct information may result in insurance denial and the patient assuming full responsibility for the balance.

We have several financial options available for your convenience to enable you to receive the proper dental care. We accept all major credit cards, debit cards, checks and cash. We offer the Care Credit Card as our extended payment option for those who qualify.

Insurance and Insurance Collection

We participate in many dental plans and we will be happy to submit your insurance claims at no charge, however, we are not responsible for the decisions made by your insurance company regarding payment or non-payment on your claim. Dental insurance is a contract between the patient and the insurance carrier, not between the carrier and the dentist. Knowing your insurance plan benefits is your responsibility. You may contact your Human Resources/Personnel Department or insurance carrier to verify your dental benefits.

A request to your insurance company to pre-authorize dental treatment will be done before treatment is started. The pre-authorization will give an overview of the projected costs allowed by your particular insurance plan. Any treatment not pre-authorized by your insurance company will necessitate payment in full for treatment by the patient. Payment for unauthorized treatment must be paid when treatment is started. Any unpaid balance is due when treatment is completed.

The estimated portion not covered by your insurance is due at the time the treatment is performed. Please be aware that we are only capable of estimating your portion and we will collect at the time services are rendered. Once the insurance company has paid their portion of the charges, if there is a balance remaining, we will mail you a statement.

Patients under the age of 18

The adult accompanying a minor and the parents (or guardian) of the minor are responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless the charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at the time of service.

Rebilling Fees

We reserve the right to assess your account with a finance charge of 1.5% for any outstanding balance over 30 days old.

Broken or Missed Appointments

We ask that patients make every effort not to change reserved dental appointments. If you find that you must change your appointment, **we require a minimum of 24 hour notice** so that we may accommodate another patient. A charge will be applied to broken and missed appointments without advanced notification.

I have read the Financial Policy and I understand and agree to the terms. I acknowledge that payment is due at the time of treatment, unless other arrangements are made in advance. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

X_____ **Date**_____

Signature of Patient or Responsible Party

X_____ **Date**_____

Signature of Co-Responsible Party (when applicable)