Dana E. Wright
DENTAL STUDIO
FAMILY | COSMETIC

PATIENT INFORMATION

Date _____

Patient _____

Address _____

_____
City State Zip

Sex ❑ M ❑ F Age _____ Birthdate _____

❑ Single ❑ Married ❑ Widowed ❑ Separated ❑ Divorced

Patient SS# _____

Occupation _____

Employer _____

Employer Address _____

Employer Phone _____

Spouse's Name _____

Birthday _____ SS# _____

Occupation _____

Spouse's Employer _____

Whom May we thank for referring you? _____

_____

DENTAL INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____
Responsible Party Signature

_____ _____
Relationship Date

PHONE NUMBERS

Cell _____ Work Phone _____ Ext. _____

Email _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

DENTAL HISTORY

Reason for today's visit _____

_____

Former Dentist _____

City/State _____

Date of last dental visit _____

Date of last dental X-rays _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bleeding gums	❑ Yes	❑ No
Blisters on lips or mouth	❑ Yes	❑ No
Burning sensation on tongue	❑ Yes	❑ No
Chew on one side of mouth	❑ Yes	❑ No
Cigarette, pipe, or cigar smoking	❑ Yes	❑ No
Clicking or popping jaw	❑ Yes	❑ No
Dry mouth	❑ Yes	❑ No
Food collection between the teeth	❑ Yes	❑ No
Grinding teeth	❑ Yes	❑ No
Gums swollen or tender	❑ Yes	❑ No
Jaw pain or tiredness	❑ Yes	❑ No
Lip or cheek biting	❑ Yes	❑ No
Loose teeth or broken fillings	❑ Yes	❑ No
Mouth breathing	❑ Yes	❑ No
Mouth pain	❑ Yes	❑ No
Orthodontic treatment	❑ Yes	❑ No
Pain around ear	❑ Yes	❑ No
Periodontal treatment	❑ Yes	❑ No
Sensitivity to cold	❑ Yes	❑ No
Sensitivity to heat	❑ Yes	❑ No
Sensitivity to sweets	❑ Yes	❑ No
Sensitivity to biting	❑ Yes	❑ No
Sores or growths in your mouth	❑ Yes	❑ No

How often do you floss? _____

How often do you brush? _____

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HEALTH HISTORY

Physician's Name _____ Physician's Phone _____ Date of last visit _____

Place a mark on **"Yes"** or **"No"** to indicate if you have had any of the following:

Anemia	❑ Yes ❑ No	Epilepsy	❑ Yes ❑ No
Arthritis, Rheumatism	❑ Yes ❑ No	Fainting or dizziness	❑ Yes ❑ No
Artificial Heart Valves	❑ Yes ❑ No	Glaucoma	❑ Yes ❑ No
Artificial Joints	❑ Yes ❑ No	Headaches	❑ Yes ❑ No
Asthma	❑ Yes ❑ No	Heart Murmur	❑ Yes ❑ No
Back Problems	❑ Yes ❑ No	Heart Problems	❑ Yes ❑ No
Bleeding abnormally, with extractions or surgery	❑ Yes ❑ No	Hepatitis Type _____	❑ Yes ❑ No
Blood Disease	❑ Yes ❑ No	High Blood Pressure	❑ Yes ❑ No
Cancer	❑ Yes ❑ No	HIV Positive	❑ Yes ❑ No
Chemical Dependency	❑ Yes ❑ No	Jaundice	❑ Yes ❑ No
Chemotherapy	❑ Yes ❑ No	Jaw Pain	❑ Yes ❑ No
Circulatory Problems	❑ Yes ❑ No	Kidney Disease	❑ Yes ❑ No
Congenital Heart Lesions	❑ Yes ❑ No	Liver Disease	❑ Yes ❑ No
Cortisone Treatments	❑ Yes ❑ No	Low Blood Pressure	❑ Yes ❑ No
Cough, persistent or bloody	❑ Yes ❑ No	Mitral Valve Prolapse	❑ Yes ❑ No
Diabetes	❑ Yes ❑ No	Nervous Problems	❑ Yes ❑ No
Emphysema	❑ Yes ❑ No	Pacemaker	❑ Yes ❑ No
		Women:	
		Are you pregnant? Due Date	❑ Yes ❑ No
		Are you nursing	❑ Yes ❑ No

Psychiatric Care	❑ Yes ❑ No
Radiation Treatment	❑ Yes ❑ No
Respiratory Disease	❑ Yes ❑ No
Rheumatic Fever	❑ Yes ❑ No
Scarlet Fever	❑ Yes ❑ No
Shortness of Breath	❑ Yes ❑ No
Sinus Trouble	❑ Yes ❑ No
Skin Rash	❑ Yes ❑ No
Special Diet	❑ Yes ❑ No
Stroke	❑ Yes ❑ No
Swelling of Feet or Ankles	❑ Yes ❑ No
Swollen Neck Glands	❑ Yes ❑ No
Thyroid Problems	❑ Yes ❑ No
Tonsilitis	❑ Yes ❑ No
Tuberculosis	❑ Yes ❑ No
Tumor of growth on head or neck	❑ Yes ❑ No
Ulcer	❑ Yes ❑ No
Weight Loss unexplained	❑ Yes ❑ No

Are you currently under medical treatment? ❑ Yes ❑ No
Have you ever had any medical operations? ❑ Yes ❑ No
If so, what? _____
Have you ever had injury or trauma to your face or jaw? ❑ Yes ❑ No
Have you ever had complications or illness following dental treatment? ❑ Yes ❑ No
Have any wounds healed slowly or presented other complications? ❑ Yes ❑ No
Are you nervous about having dental work done? ❑ Yes ❑ No
Do you have any concerns with your teeth's appearance? ❑ Yes ❑ No

MEDICATIONS

List medications you are currently taking:

_____
_____
_____
_____

Pharmacy Name _____

Phone _____

ALLERGIES

❑ Aspirin
❑ Barbiturates (sleeping pills)
❑ Codeine
❑ Iodine
❑ Latex _____
❑ Metals or Jewelry
❑ Local Anesthetic
❑ Penicillin
❑ Sulfa
❑ Other _____
_____

HIPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT / LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not by allowed* to process your insurance claims.

Date:_____ E-mail: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____

Please ***print*** name of Patient Please ***sign*** for Patient/Guardian of Patient

_____ _____

Legal Representative/Guardian Relationship of Legal Representative Guardian

Your comments regarding Acknowledgements: _____

_____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

☐ First Name Only ☐ Proper Sir Name ☐ Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship: _____

Name:_____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENTS, & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation ☐ Text Message to my Cell Phone
☐ Home Phone Confirmation ☐ Email Confirmation
☐ Work Phone Confirmation ☐ **Any of the Above**

In signing this HIPAA Omnibus Patient Acknowledgement Form, you authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's signature on this Acknowledgement but did not because:

It was emergency treatment ☐
I could not communicate with the patient ☐
The patient refused to sign ☐
The patient was unable to sign because:

_____ _____

Signature of Privacy Officer

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Financial Policy of Dana E. Wright, D.D.S.

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. Please understand that payment is considered part of your treatment. The following statement of our financial policy, which we require that you read, agree to, and sign prior to any treatment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and Care Credit.

Please note: Returned checks will be subject to additional fees.

If you have insurance:

- As a courtesy to you, we will help you process all your insurance claims. Please understand that we will provide an insurance estimate to you, however it is not a guarantee that your insurance will pay exactly as estimated. Your insurance company and your plan benefits ultimately determine the amount paid. We will, of course, do all we can to make sure your estimate is as accurate as possible.
- All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company, Your insurance policy is a contract between you, your employer, and your insurance company. Our office is not a party to that contract.
- Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
- We ask that you sign this form and/or any other necessary documents that may be required by your insurance company. This form instructs your insurance company to make payment directly to our office.
- We ask that you pay the deductible and co-payment, which is the estimated amount, not covered by your insurance company, by cash, check, MasterCard, Visa or Care Credit at the time we provide the service to you.
- Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 30 days, we will ask that you contact your insurance company to make sure payment is expected soon. If payment by your insurance company is not received within 60 days, or your claim is denied, you will be responsible for paying the full amount at that time.

We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. Our office will not, however, enter into a dispute with you insurance company over any claim.

Minors with Separated of Divorced Parents:

When two parents are each responsible for one half of the cost of a child's dental care, the Parent or Guardian who brings the child is responsible for the co-insurance or the full fee. They will also be responsible for collecting payment from the other parent.

For your convenience, we also offer automatic payments to your credit card as a form of payment. Please let us know if you would like to use this method of payment, as there is an additional authorization form to sign.
Thank you for the opportunity to serve your dental health care needs.

In the case it becomes necessary for our office to enlist a collection service and/or legal assistance; you will be responsible for any collection and/or legal charges incurred, along with any charges associated with those agencies, and/or finance charges. I/we agree that in the event of default in payment, reasonable collection agency fees equal to fifty (50%) percent of the delinquent balance and reasonable attorney fees, shall be added to the amount due on the account, plus any applicable court costs.

_____ _____

Initials Date

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE.

_____ _____

Patient Name Signature of Guarantor, if Minor Date