TIME 02:06 PM DATE 2/14/2019

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Emergency Contact

Emergency Number

Times/day brushing?

Times/day flossing?

Like your smile?

Last dental x-rays?

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Patient Dental History

Name_____

Name of previous dentist and location_____ Date of last exam_____

Circle one

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to hot or cold liquids/foods? Yes No

Are your teeth sensitive to sweet or sour liquids/foods? Yes No

Do you feel pain to any of your teeth? Yes No

Do you have any sores or lumps in or near your mouth? Yes No

Have you ever experienced any of the following problems in your mouth?

Clicking Yes No

Pain (joint, ear, side of face) Yes No

Difficulty opening or closing Yes No

Difficulty chewing Yes No

Do you have frequent headaches? Yes No

Do you clench or grind your teeth? Yes No

Do you bite your lips or cheeks frequently? Yes No

Have you ever had difficult extractions? Yes No

Have you ever had prolonged bleeding after extractions? Yes No

Have ever had orthodontic treatment (braces)? Yes No

Do you wear dentures or partials? Yes No

If yes, date of placement_____

Have you ever received oral hygiene instructions

regarding the care of your teeth and gums? Yes No

Time 2:08 PM | Wolf Family Dentistry, P.C. | Date 2/14/2019

Eaglesoft Medical History

Patient Name: | Birth Date: | Date Created:

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	
Have you ever been hospitalized or had a major operation?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Are you taking any medications, pills, or drugs?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes	
Are you on a special diet?	Yes No		
Do you use tobacco?	Yes No		
Do you use controlled substances?	Yes No	If yes	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

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

Other? ☐ If yes

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 Problems 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 If yes

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:

X Date:_____

Consent to Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read and initial the items below and sign at the bottom of the form.

1. Treatment to be Provided

I understand that during my course of treatment that the following care may be provided: Examinations, Preventive Services, Restorations, Crowns, Bridges, and other.
Patient Initials_____

2. Drugs and Medications

I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
Patient Initials_____

3. Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.
Patient Initials_____

4. I give permission to the dental office to bill my dental insurance for the treatment provided, if applicable.
Patient Initials_____

Patient/Guardian Signature_____
Date_____

Wolf Family Dentistry
3550 W Johnson Road
La Porte, IN 46350

Contact Information for Protected Health Information

I, _____(patient), Date of Birth_____, request that the following be allowed for the disclosure of my Protected Health Information (PHI). Protected Health Information would include your name, diagnosis, test results, date of service.

- Sensitive Protected Health Information (HIV related information)
- You may disclose information to my family members and/or non-family members

Please list the name, phone number and relationship

NAME PHONE NUMBER RELATIONSHIP

_____

_____

_____

___You may leave Protected Health Information on my answering machine/voicemail: Phone number_____

___You may text me for dental appointments : phone number_____

___You may email me for dental appointments: Email Address_____

___You may fax me for dental information: Fax Number_____

___Other_____

A copy of this office's Notice of Privacy Practices is available at the front desk.

Print Patient Name:_____

Signature of patient or guardian:_____

Date:_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but could not be obtained because:

___ Individual refused to sign
___ Communication barriers prohibited obtaining the acknowledgement
___ An emergency situation prevented us from obtaining acknowledgement
___ Other (please specify)

Wolf Family Dentistry, P.C.

Protecting the privacy of your personal health information is important to us. This notice describes how information about you may be used and disclosed and how you can get access to this information.

Disclosure of your protected health information without authorization is strictly limited to defines situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. You understand and agree to allow this office to use your patient health information for the purpose of treatment, payment, healthcare operations and coordination of care. You may request restrictions on disclosures.

Disclosures of protected health information are limited to the minimum necessary for the purpose of the disclosure. This provision does not apply to the transfer of medical records for treatment.

You may inspect and receive copies of your records within 30 days of a request to do so and a cost-based fee for photocopying, postage and preparation may apply.

You may request changes to your records which our office has the right to accept or deny.

We maintain a history of protected health information disclosures that is accessible to you.

In the future, we may contact you for appointment reminders, announcements, and to inform you about our practice and its staff.

Our office is required to abide by this notice. We have the right to change this notice in the future. Any revisions will be displayed in a clearly visible location in our office.

You may file a complaint about privacy violations by contacting our office at 219-362-3730.

If you would like to have a more detailed account of our policies and procedures concerning the privacy of your protected health information we encourage you to request and read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

Please sign on one of the lines below.

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Printed name_____

Patient Signature (or Guardian Signature)_____

Date_____

Wolf Family Dentistry
Office Financial Agreement

Your understanding of our financial policy is an essential part of your care and treatment. If you have any questions, please don't hesitate to discuss them with us.

As a courtesy, we will contact your insurance carrier to verify your coverage, but this is only an estimate of what the insurance company will pay until we receive an actual payment. It is not a guarantee of payment.

Your insurance policy is a contract between you and your insurance company. Also as a courtesy, we will file your insurance claims for you , but you are ultimately responsible for full payment. Patients are encouraged to contact their carrier for clarification of benefits prior to services being rendered. If we are unable to verify coverage you will be required to pay in full for services rendered.

Due to frequent erroneous information given to us from insurance carriers and the frequent difficulty in collecting payments from the carrier, we may ask for active assistance from you in rectifying the situation.

All payments such as deductibles and co-payments are due at the time of service. Most insurance's do not cover 100% of services rendered.

After 60 days, any outstanding balances will be due in full by you. Balances over 60 past due will be subject to collection proceedings by an independant collection agency or small claims court. In this event you will be responsible for all service fees incurred.

You must inform this office of all insurance changes. In the event the office is not informed of any changes, you will be reponsible for any charges denied as a result.

We accept cash, check, MasterCard/Visa, Discover, American Express.
We also accept Care Credit (subject to credit approval) with plan options up to 24 months interest free depending on the amount financed.

I have read and understand the above financial policy. By signing below I am taking responsibility for all fees incurred. This form <u>MUST</u> be signed by the person who will be responsible for paying the balance on the patient account.

Patient Name_____

Responsible Party Signature_____ **Date**_____

Wolf Family Dentistry appreciates your efforts to cancel your scheduled appointments at least 24 hours in advance.

When you call to cancel a scheduled appointment with at least 24 hour notice we have the opportunity to refill that appointment with another patient in need. Please help us meet another patient's need by calling in advance to cancel or reschedule your appointments.

Effective immediately, there will be a $25.00 fee for No-Shows to any scheduled appointments. You will be charged a no-show fee under the following circumstances:

1. **You do not contact us and do not attend your scheduled appointment.**
2. **You contact us to cancel your appointment on the same day as your scheduled appointment.**

Patients arriving more than 15 minutes late for an appointment will not be able to meet with their provider that day and the appointment will be considered a no-show appointment.

To cancel an appointment you may call our office at **219-362-3730**.

Again, thank you for letting us know in advance if you cannot make your scheduled appointment so that we may serve other patients during that time.

I,_____, have read and understand the policy stated above.

Signature_____ Date_____