WELCOME

Patient Name:______________________ Today's Date:______________

Nickname:______________________ [ ] Male [ ] Female

Date of Birth:______________________ SS#:______________________

Address:______________________ City:______________

State:________ Zip:__________ E-mail:______________________

Employer:______________________ Occupation:______________________

Home#:______________________ Cell#:______________________

Work #:______________________ Ext:______________

Where do you prefer to receive calls? [ ] Home [ ] Work [ ] Cell

Emergency contact: Name:______________ Relat:______________ #:______________

Referred By:______________________

*****We do not accept personal checks** ****** $35.00 fee if appt cancelled less than 48 hours**

Ask the front desk how to apply for CareCredit® payment plan.

Responsible Party -- If "same" as above check here [ ] and go to next section

Patient Name:______________________ Relationship:______________________

Home#:______________ Cell#______________ Work #:______________

Primary Dental Insurance

Insured Name:______________________ Relation to Patient:______________________

Date of Birth:______________________ SS#/Emp ID#:______________________

Employer:______________________ Occupation:______________________

Insurance Company:______________________ Group #:______________________

Provider phone #:______________________

Authorization and Release

I understand that I am responsible for payment of dental services in this office for myself and my dependents. This payment is due and payable at the time services are rendered unless financial arrangements have been made. I understand that I am responsible for all costs of collection including attorney fees, collection fees and court costs. I understand that any unpaid balance will be assessed interest at the rate of 21.00% (1.75% monthly). **Insurance claims are filed as a courtesy, but it is my responsibility to see that claims are paid. I fully understand that I am responsible for payment of fees not covered by insurance.** I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I authorize the submission of claims without obtaining my signature on each and every claim submitted.

I authorize and consent for treatment after a full explanation of proposed treatment, alternatives and risks by my doctor.

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health practitioners.

Signature ______________________________ Date: ____________________

ACKNOWLEDGEMENT OF NOTIFICATION OF PRIVACY PRACTICES

I have been advised of my privacy rights as provided by the Healthcare Information Portability and Accountability Act of 1996. I have reviewed and understand Wahl Dental Group's **Notice of Privacy Practices.**

Signature ______________________________ Date ____________________

ACKNOWLEDGEMENT OF NOTIFICATION OF FINANCIAL POLICY

I have reviewed and understand Wahl Dental Group's **Financial Policy.** I hereby authorize this provider and its employees, agents and assignees to contact me via e-mail, text messaging and to my cellular devices.

Signature ______________________________ Date ____________________

____________________For Office Use Only____________________

We have attempted to obtain written acknowledgement of review or Notice of Privacy Practices and the Financial Policy, but acknowledgement could not be obtain.

Individual refused to sign [ ]Privacy Practices [ ]Financial Policy

Comments:____

____

Signature:______________________________

DENTAL HISTORY

Patient Name

Welcome! So that we may provide you with the best possible care
Please complete both sides of the medical/dental history form.
All information is completely confidential.

What is the reason for your visit?______________________________

Date of Last Dental Visit______________ Last Dental Cleaning______________ Last Full Mouth X-rays______________

What was done at your last dental visit?______________________________

____

Previous Dentist's Name______________________________

Address______________________________ State______________ Zip______________

Telephone______________________________

How often do you have dental examinations?______________________________

How often do you brush your teeth?______________ How often do you floss?______________

What other dental aids do you use?(Toothpick, elec. Toothbrush,etc.)______________________________

Do you have dental problems now? **NO** **YES**

If yes, please describe:______________________________

Are any of your teeth sensitive to:

Hot or cold?	Yes	No
Sweets?	Yes	No
Biting or Chewing?	Yes	No
Have you noticed any mouth odors or bad tastes?	Yes	No
Do you frequently get cold sores, blisters Or lesions?	Yes	No
Do your gums hurt or bleed?	Yes	No
Have your parents experienced gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
Does food tend to become caught between your teeth?	Yes	No

If yes where?______________

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Hold foreign objects with your teeth? (pencils, pipe, pins, nails, etc?)	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No
Smoke/chew tobacco?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal Treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard?	Yes	No
A serious injury to the mouth or head?	Yes	No

If so, please describe, including cause______________

____

Have you experienced:

Clicking or popping of the jaw?	Yes	No
Pain?(joint, ear, side of face)	Yes	No
Difficulty in opening or closing the mouth?	Yes	No
Difficulty in chewing on either side of the mouth?	Yes	No
Headaches, neck aches or shoulder aches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No

Are you satisfied with your teeth's appearance?	Yes	No
Would you like to keep all of your teeth all of your life?	Yes	No
Do you feel nervous about having dental treatment?	Yes	No

If so, what is your biggest concern?

____

Have you ever had an upsetting dental experience?	Yes	No

If yes, please describe______________

____

Is there anything else about having dental treatment that you would like us to know? **YES** **NO**

If yes, please describe______________________________

____

____

(Please complete other side)

MEDICAL HISTORY

Patient Name

1. Have you been under the care of a medical doctor during the past two years?.. Yes No
   If yes, for what?____
   Physician's Name______________________________Phone______________________
   Address____________________________City______________State__________Zip__________

2. Have you taken any medication or drugs during the past two years?.. Yes No

3. Are you taking any medication, drugs or pills now, including regular dosages of aspirin?.. Yes No
   If yes, please list name and dosage____

4. Have you ever taken prescription medications for weight loss? (diet pills)?.. Yes No
   If yes, did you take any of the following: Yes No Fen-Phen (Fenfluramine-Phentermine)
   Yes No Pondimen (Fenfluramine)
   Yes No Redux (Dexfenfluramine)
   If yes, to any of the above, did you have a medical exam for heart issues?... Yes No

5. Are you aware of having an allergic (or adverse) reaction to any medication or substance?... Yes No
   If yes, please list____

6. Have you been a patient in the hospital during the past five years?.. Yes No

7. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart Disease	Yes	No	Ulcers	Yes	No	Hepatitus A(infectious)B(Serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High blood Pressure	Yes	No	Contact Lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Hay Fever	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Allergies or Hives	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints(hip,knee,etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

8. Do you use more than two pillows to sleep? Yes No

9. Have you lost or gained more than 10 pounds in the past year? Yes No

10. Do you have or have you had any disease, condition, or problem not listed? Yes No
    If yes, please list____

11. Women: Are you : Pregnant? Yes Months_____ No Nursing? Yes No Taking Birth Control Pills? Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature____Date__________________

History Review

Dentist Signature____Date__________________