WABASHA DENTISTRY

wabashadentistry.com
Wabasha Dentistry | 207 Main St W • Wabasha, MN 55981
contactus@wabashadentistry.com
(651)565-3511

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Preferred method for us to contact you

☐ Home ☐ Cell ☐ Work ☐ Text ☐ Email

Whom may we thank for referring you to our practice?

_____

Responsible Party Information:

This only needs to be filled out if the insurance subscriber is other than patient, or if patient is under 18.

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Patient Name: _____ (Last) _____ (First) ___ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work) _____ (Ext) _____ (Fax) _____ (Other)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Employment Information:

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Dental Insurance

Please bring your insurance card with you to your appointment and present to our front desk staff so that we can efficiently process you claim.

Primary Dental Insurance:

Insurance Company Name and Phone Number:

_____

_____

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

_____

_____

Secondary Dental Insurance

Insurance Company Name and Phone Number:

_____

_____

Insurance Subscriber ID, Date of Birth, and Insurance Group Number:

_____

_____

Insurance Authorization:

☐ **By checking this box**
I authorize my insurance company to pay the dentist all insurance benefits rendered directly or, when applicable, remit the check I receive from the insurance company to the dental practice upon receipt.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care Financial responsibility on the part of each patient must be determined before treatment. For minor patients the parent making the appointment and/or bringing the child to his/her appointment will be assumed the party responsible for payment unless a signed statement from another responsible party is obtained.

All emergency dental services must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1 5% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 30 days, unless previously written financial arrangements are satisfied. A $25 service charge will be issued for all returned checks.

I understand that any fee estimate for dental treatment can only be extended for a period of 90 days from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within twenty-five (25) days of the billing statement date. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

PAYMENT OPTIONS. We offer 3 payment options for your convenience:

1) Dental practice will submit insurance claims. I will pay balance in full after claims are received.

2) Pay in full at the time of service with Cash or Check for a 5% bookkeeping discount

3) Pay in full at the time of service with a third party lending company, allowing payment within 1 year, interest free.

Unfortunately we can not offer discounts for insured patients. Doing so would inaccurately represent your treatment expenses and would be a violation of your contract with your insurer.

If you have any questions or concerns, please contact our front office team at 651-565-3511

Payment option chosen *

☐ 1 ☐ 2 ☐ 3

☐ ***By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Consent for Services and Financial Policy form.**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information, appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. I also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ **I have read the information above regarding the secured uploading of patient information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient information to the web site.**

Consent for Photo Release

We are proud of our part in keeping and making our patients' smiles healthy. To celebrate this we periodically ask to use our patients' photos on our website, Facebook page, waiting room photo album and/or marquis screen, or in the case of our younger patients, on our "No Cavity Club" photo wall. Only first names, if any at all, are used. Photos will be removed immediately upon request.

☐ **I have read the above information about the use of my photograph and I grant the dental practice permission to use my photograph.**

HIPAA Acknowledgement

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected heath information. A written copy of our Notice will be provided upon request and an electronic copy may be viewed on our website. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protectd health information that we maintain.
Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Wabasha Dentistry. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may declince to treat you or to continue treating you if you revoke this Consent.
I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality. I understand that the dental practice will never release my personal information to a third party for commercial or solicitation reasons.

☐ **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form. (Failure to check will assume a refusal to sign the acknowledgement)**

Name of the Patient, Parent or Guardian completing this form: *

_____

_____

Relationship to patient: *

◯ Self ◯ Parent ◯ Guradian ◯ Spouse ◯ Other

Response Date: ___/___/_____

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Welcome to our Practice

In an emergency who should be notified? Name, Phone Number, and Relationship to patient: *

Medical History

ALLERGIES *

☐ Anesth ☐ Meds ☐ Food ☐ Latex ☐ Other ☐ None

Please explain any checks above and reaction

Have you had any surgeries or hospitalizations in the last year? If yes, please explain:

Indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response, leaving blank will indicate a "NO" response.

☐ Acid Reflux / GERD	☐ ALLERGIES	☐ Anemia	☐ ANTIBIOTIC PREMED
☐ Antibiotic Resistant	☐ Anxiety	☐ Arthritis	☐ Artificial Joints
☐ Asthma	☐ AVOID EPINEPHERINE	☐ Blood Clots	☐ Blood Disorders
☐ Blood Thinners	☐ Cancer	☐ Celiac Disease	☐ Chemical Dependency
☐ Chest Pain / Angina	☐ Damaged Heart Valve	☐ Defib / Pacemaker	☐ Delayed Healing
☐ Depression	☐ Diabetes	☐ Dialysis	☐ Difficulty Breathing
☐ Dimentia/Alzheimer's	☐ Do Not Resuscitate	☐ Eating Disorder	☐ Epilepsy/Seizures
☐ Excessive Bleeding	☐ Fainting/Dizziness	☐ Fibromyalgia	☐ Headaches/Migraines
☐ Heart Attack	☐ Heart Failure	☐ Heart Infection	☐ Heart Problems
☐ Heart Surgery	☐ Hepatitis	☐ High Blood Pressure	☐ High cholesterol
☐ HIV/AIDS	☐ Imp'd Vision/Hearing	☐ Kidney Disorder	☐ Liver Disease
☐ Low Blood Sugar	☐ Lupus	☐ Multiple Sclerosis	☐ Organ Transplant
☐ Osteoporosis	☐ Other	☐ Parkinson's	☐ Recent Weight Change
☐ Recovered Alert	☐ Recovered Alert	☐ Recovered Alert	☐ Sinus Problems
☐ Sjogren's Syndrome	☐ Skin Conditions	☐ Sleep Apnea	☐ STD/VD
☐ Stroke	☐ Thyroid Hypo/Hyper	☐ Tuberculosis	☐ Ulcers

Medical History continued:

Explanations for any of the previous conditions

Do you use tobacco?

☐ Yes ☐ No ☐ I am interested in quitting

Women - check those that apply

☐ Pregnant ☐ Birth control ☐ Hormone Replacement

Any other health concerns not already listed?

Have you required Pre-medication prior to dental visits? Check those that apply and explain in the space below: *

☐ Yes ☐ No ☐ Antibiotic ☐ Anti-anxiety

MEDICATIONS (Please list any medications, drugs, pills or herbal remedies, including regular dosages of aspirin you are currently taking): If you already have a written list we can make a copy.

Name of your medical doctor/physician/clinic and your most recent physical exam:

☐ ***By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.**

Dental Information

What is the reason for your visit today?

_____

_____

Name/Address of previous Dentist:

_____

_____

Date of most recent dental exam and x-rays? _____

I routinely see my dentist and/or hygienist every:

☐ 3 mos. ☐ 4 mos. ☐ 6 mos. ☐ 12 mos. ☐ Not routinely

How would you rate the condition of your oral health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Do you currently have: (check all that apply)

☐ Bleeding gums
☐ Unpleasant taste or odor
☐ Dental implants
☐ Sensitive teeth (hot, cold, sweets)
☐ Loosening of teeth
☐ Dental pain
☐ Gum recession
☐ Sores or swelling in your mouth
☐ Snoring (or someone told you you do)
☐ Night-time grinding or snoring device
☐ Whitening trays
☐ Full or parital dentures
☐ Dry mouth

Dental History: Have you ever had any of the following? (check all that apply)

☐ Unfavorable dental experience
☐ Braces/orthodontic treatment
☐ Oral surgery
☐ Reactions to local anesthetic
☐ Difficulty getting numb
☐ Gum treatment and/or surgery
☐ Complications from past dental treatment

Smile Characteristics. Check any of the following that tell us how you feel about your smile:

☐ Unhappy with the appearance ☐ Would like smile to look different ☐ Would like teeth whiter ☐ Would like straighter teeth

Bite and Jaw Joint: (check all that apply)

☐ Pain ☐ Difficulty chewing ☐ Teeth seem to be moving ☐ Clicking or sounds ☐ Knowingly clench or grind
☐ Difficulty opening/closing ☐ Have noticed tooth wear

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

How often do you brush your teeth? _____

How often do you floss your teeth (or other method to clean between teeth)? _____

_____

Response Date: ___/___/_____