whiting dental

Date_____

Patient _____
Last Name First Name Initial Preferred Name

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Email _____

How would you like us to contact you? Home - Work - Cell - Email - Text

Address_____ Birthdate _____ Social Security # _____ - _____ - _____

City _____ State _____ Zip _____

Sex: ___M ___F Status: ___Child/Dependent ___Single __Married __Widowed ___Divorced

Employer _____ Occupation _____

Spouse/Parent Name _____ Birthdate _____ Social Security # _____ - _____ - _____

Spouse/Parent Employer _____ Business Phone (_____)_____

Who is responsible for this account?_____ Relationship to patient _____

Name of Dental Insurance Company _____ Insurance Phone (_____)_____

Group Number _____ Insurance ID#: _____

In case of emergency, whom should we notify?_____ Phone (_____)_____

Whom may we thank for referring you?_____

MEDICAL HISTORY

Physician's Name _____ Date of Last Physical _____

Have you ever had any of the following? (put check mark next to those that apply):

__ Arthritis
__ Artificial Heart Valves or Joints
__ Asthma
__ Back Problems
__ Blood Disease
__ Cancer
__ Chemical Dependency
__ Chronic Diarrhea
__ Circulatory Problems
__ Diabetes
__ Epilepsy
__ General Allergies
__ Headaches
__ Heart Murmur
__ Hemophilia
__ Hepatitis, Jaundice or Liver Disease
__ High Blood Pressure
__ HIV/ AIDS other Immunosuppressive Disorders
__ Low Blood Pressure
__ Mitral Valve Prolapse
__ Nervous Problems
__ Pacemaker
__ Psychiatric Care
__ Radiation Treatment
__ Recent Weight Loss
__ Respiratory Disease
__ Rheumatic Fever
__ Sinus Problems
__ Special Diet
__ Stroke
__ Swollen Neck Glands
__ Tuberculosis
__ Ulcer
__ Venereal Disease

Do you have any drug allergies or have you ever had an adverse reaction to any medication?_____ If so, what _____

Have you ever responded adversely to medical or dental treatment? _____

Do you need to take prophylactic antibiotics prior to dental treatment? _____

Are you taking any medication at this time including birth control pills?_____ If so, what _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin, (phentermine), Pondimin (fenfluramine) and Redux (dexfenflurine). __Yes __No

Are you under the care of a physician? __Yes __No For what conditions? _____

If patient is a child, what is his/her weight? _____

(Women) Do you suspect that you are pregnant? __Yes __No Are you nursing? __Yes __No

Is there anything else we should know about your medical history? _____

_____ _____
Dr. Signature Dr. Initial

(OVER)

ACKNOWLEDGEMENT

The previously stated information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits for which I am entitled. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of the form.

Date _____ Signature _____

INSURANCE ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
And assign directly to Dr. Ben Whiting all 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 payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

MINOR/CHILD CONSENT

I, being the parent or guardian of _____ do hereby request and authorize the dental staff to perform necessary dental services for my child, including but not limited to X-rays, and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered.

Date _____ Signature _____

FINANCIAL POLICY

Payment is expected at time of treatment. We will gladly bill insurance as a courtesy; however, most insurance companies do not provide 100% of your payment. You are responsible for any charges not covered by your insurance. We do not extend payments unless prior arrangements have been made by our office manager. Finance charges of 1.5% will be added to any account over 60 days. In the event your account is turned over to an outside collection agency for non-payment or other delinquency, your will be responsible for payment of any collection costs and / or attorney fees, in addition to the balance owed.

Date _____ Signature _____

APPOINTMENT POLICY

Failed appointments are a significant contributor to rising health care costs. We require 24-hour notice for any appointment that you are unable to keep. A $47.00 fee will be charged to your account if you miss or cancel without the required 24 hours.

Date _____ Signature _____

PRIVACY POLICY

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Date _____ Signature _____