

PATIENT MEDICAL HISTORY

Patient's Name: _____ Date Of Birth: _____

Address: _____ City: _____

State: _____ Zip: _____ Email: _____

Phone #'s Home: _____ Work: _____ Cell: _____

Preferred Contact Method: _____ Social Security Number: _____

Emergency Contact: _____ Contact's Phone: _____

Physician's Name: _____ Physician's Phone: _____

Medications: Please list: _____

Do you or have you taken biphosphinates (Aredia or Zometa) orally or by IV? Y N

Conditions:

Y N

- Acid Reflux
- Anemia
- Angina
- Arthritis
- Asthma
- Bipolar
- Blood Disorder
- Blood Transfusion
- Cancer
- Chemotherapy
- Clotting Disorder
- Colitis
- Depression
- Diabetes
- Emphysema

Y N

- Epilepsy
- Fainting Spells
- Fever Blisters
- Glaucoma
- HIV/AIDS
- Heart Attack
- Heart Defect
- Heart Disease
- Heart Failure
- Heart Murmur
- Heart Valve Replaced
- Heart Surgery
- Hemophilia
- Hepatitis A/B/C
- High Blood Pressure

Y N

- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Migraines
- Neurologic Disorder
- Pace Maker
- Radiation Therapy
- Seizures
- Sinus Problems
- Sleep Disorder
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies:

Y N

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Hay fever/Seasonal

Y N

- Iodine
- Latex
- Metals
- Penicillin
- Sulfa Drugs
- Other _____

Do you have any diseases, conditions or problems not listed above that we should know about? If so, please explain: _____

Have you ever been advised by a physician to pre-medicate prior to dental work? Y N

Please answer: Y N <input type="checkbox"/> <input type="checkbox"/> Do you use tobacco? <input type="checkbox"/> <input type="checkbox"/> Do you drink alcoholic beverages?	Women Only Y N <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? If Yes, # of weeks _____ <input type="checkbox"/> <input type="checkbox"/> Are you nursing? <input type="checkbox"/> <input type="checkbox"/> Are you taking birth control pills?
Dental Information: Y N <input type="checkbox"/> <input type="checkbox"/> Are you currently experiencing dental pain or discomfort? <input type="checkbox"/> <input type="checkbox"/> Do your gums bleed when you brush or floss? <input type="checkbox"/> <input type="checkbox"/> Are your teeth sensitive to cold, hot, sweets or pressure? <input type="checkbox"/> <input type="checkbox"/> Does food or floss catch between your teeth? <input type="checkbox"/> <input type="checkbox"/> Is your mouth dry? <input type="checkbox"/> <input type="checkbox"/> Have you had any periodontal (gum) treatments? <input type="checkbox"/> <input type="checkbox"/> Have you ever had orthodontic (braces) treatment? <input type="checkbox"/> <input type="checkbox"/> Have you ever had any problems with previous dental treatment? <input type="checkbox"/> <input type="checkbox"/> Do you have earaches or neck pains? <input type="checkbox"/> <input type="checkbox"/> Do you have any clicking, popping or discomfort in the jaw?	

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. By signing, I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: _____ Date: _____

If you completed this form on behalf of the patient, what is your name and relationship to that person?

Name: _____ Relationship: _____

Spouse or Responsible Party Information

The following is for: the patient's spouse the person responsible for payment

Name _____
 Male Female Married Single Child Other _____
 Social Security#: _____ Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____ Best time to call: _____
 Address: _____
 Street _____ Apartment # _____
 City _____ State _____ Zip Code _____

Employment Information

The following is for: the patient the person responsible for payment

Employer Name: _____ Occupation: _____
 Address: _____
 Street _____ City _____ State _____ Zip Code _____ Phone _____

Insurance Information

Primary

Name of Insured _____ Is insured a patient? Yes No
 Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____
 Insured's Address: _____
 Street _____ City _____ State _____ Zip Code _____
 Insured's Employer Name: _____
 Address: _____
 Street _____ City _____ State _____ Zip Code _____
 Patient's relationship to insured: Self Spouse Child Other _____
 Insurance Plan Name and Address: _____

Secondary

Name of Insured _____ Is insured a patient? Yes No
 Last First MI
 Insured's Birth Date: _____ ID #: _____ Group #: _____
 Insured's Address: _____
 Street _____ City _____ State _____ Zip Code _____
 Insured's Employer Name: _____
 Address: _____
 Street _____ City _____ State _____ Zip Code _____
 Patient's relationship to insured: Self Spouse Child Other _____
 Insurance Plan Name and Address: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished 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 patients insurance forms or assist in making collections from insurance companies and will credit any such 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% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. 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 at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent or guardian _____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party _____ Date: _____ Relationship to Patient: _____

Written Financial Policy

Thank you for choosing Willowbrook Dental Associates. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Personal Check or Credit Card
- NO INTEREST Payment Plans through Care Credit
 - Allow you to pay over time with NO INTEREST
 - Convenient, low monthly payment plans also available
 - No annual fees or pre-payment penalties

PLEASE NOTE:

Willowbrook Dental Associates requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is completed, you will receive a refund less the cost of care received.

For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment. Any estimate that you are given in regards to your insurance is ONLY AN ESTIMATE. We cannot guarantee payment from your insurance company and additional costs may arise due to your dental needs.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and need.

Patient, Parent or Guardian Signature

Date

Patient Name (Please Print)