PATIENT MEDICAL HISTORY

Patient's Name:_____ Date Of Birth:_____

Address:_____ City:_____

State: _____ Zip:_____ Email:_____

Phone #'s Home:_____ Cell:_____

May our office send billing statements via Text message? Please circle YES or NO

Please circle your preference for appointment reminders TEXT/AUTOMATED CALL/BOTH

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		Y	N		Y	N	
☐	☐	Acid Reflux	☐	☐	Epilepsy	☐	☐	Joint Replacement
☐	☐	Anemia	☐	☐	Fainting Spells	☐	☐	Kidney Problems
☐	☐	Angina	☐	☐	Fever Blisters	☐	☐	Liver Disease
☐	☐	Arthritis	☐	☐	Glaucoma	☐	☐	Low Blood Pressure
☐	☐	Asthma	☐	☐	HIV/AIDS	☐	☐	Migraines
☐	☐	Bipolar	☐	☐	Heart Attack	☐	☐	Neurologic Disorder
☐	☐	Blood Disorder	☐	☐	Heart Defect	☐	☐	Pace Maker
☐	☐	Blood Transfusion	☐	☐	Heart Disease	☐	☐	Radiation Therapy
☐	☐	Cancer	☐	☐	Heart Failure	☐	☐	Seizures
☐	☐	Chemotherapy	☐	☐	Heart Murmur	☐	☐	Sinus Problems
☐	☐	Clotting Disorder	☐	☐	Heart Valve Replaced	☐	☐	Sleep Disorder
☐	☐	Colitis	☐	☐	Heart Surgery	☐	☐	Stroke
☐	☐	Depression	☐	☐	Hemophilia	☐	☐	Thyroid Problems
☐	☐	Diabetes	☐	☐	Hepatitis A/B/C	☐	☐	Tuberculosis
☐	☐	Emphysema	☐	☐	High Blood Pressure	☐	☐	Ulcers

Allergies:

Y	N		Y	N	
☐	☐	Aspirin	☐	☐	Iodine
☐	☐	Codeine	☐	☐	Latex
☐	☐	Dental Anesthetics	☐	☐	Metals
☐	☐	Erythromycin	☐	☐	Penicillin
☐	☐	Hay fever/Seasonal	☐	☐	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:	Women Only
Y N	Y N
☐ ☐ Do you use tobacco?	☐ ☐ Are you pregnant?
☐ ☐ Do you drink alcoholic beverages?	If Yes, # of weeks_____
	☐ ☐ Are you nursing?
	☐ ☐ Are you taking birth control pills?

Dental Information:

Y N

☐ ☐ Are you currently experiencing dental pain or discomfort?
☐ ☐ Do your gums bleed when you brush or floss?
☐ ☐ Are your teeth sensitive to cold, hot, sweets or pressure?
☐ ☐ Does food or floss catch between your teeth?
☐ ☐ Is your mouth dry?
☐ ☐ **Have you had any periodontal (gum) treatments?**
☐ ☐ **Have your ever had orthodontic (braces) treatment?**
☐ ☐ **Have you ever had any problems with previous dental treatment?**
☐ ☐ **Do you have earaches or neck pains?**
☐ ☐ **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:**_____

Regarding HIPPA Privacy Laws, Please list the person/s that we may discuss your treatment with:

Name: _____ **Relationship:** _____

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.

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

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

Notice of Privacy Practices Acknowledgment

Practice Name: Willowbrook Dental Associates
Address: 259 Old Route 30 Suite D Greensburg, PA 15601
Phone: 724-836-6884

Patient Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of this dental practice's **Notice of Privacy Practices**, which describes how my health information may be used and disclosed and how I can access this information.

I understand that:

- This practice has a Notice of Privacy Practices available for review.
- The Notice explains how my medical and dental information may be used for treatment, payment, and healthcare operations.
- The Notice outlines my rights regarding my protected health information under the Health Insurance Portability and Accountability Act (HIPAA).
- I may request a copy of the Notice at any time.

I have had the opportunity to ask questions regarding this Notice.

Patient Information

Patient Name (Printed): _____

Patient Signature: _____

Date: _____

If signed by personal representative:

Representative Name (Printed): _____

Relationship to Patient: _____

Signature of Representative: _____

Date: _____

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)