

WELCOME

PATIENT INFORMATION

Date _____
SS/HIC/Patient ID # _____
Patient _____
Address _____
City _____
State _____ Zip _____
E-mail _____
Sex ☐ M ☐ F Age _____
Birthdate _____
☐ Married ☐ Widowed ☐ Single ☐ Minor
☐ Separated ☐ Divorced ☐ Partnered for _____ years
Occupation _____
Patient Employer/School _____
Employer/School Address _____
Employer/School Phone (_____) _____
Spouse's Name _____
Birthdate _____
SS# _____
Spouse's Employer _____
Whom may we thank for referring you? _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to Patient _____
Insurance Co. _____
Group # _____
Is patient covered by additional insurance? ☐ Yes ☐ No
Subscriber's Name _____
Birthdate _____ SS# _____
Relationship to Patient _____
Insurance Co. _____
Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to
Name of Insurance Company(ies) _____
Dr. _____ all insurance 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 authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative _____

Please print name of Patient, Parent, Guardian or Personal Representative _____

Date _____

Relationship to Patient _____

PHONE NUMBERS

Home (_____) _____ Work (_____) _____ Ext _____ Cell Phone (_____) _____
Spouse's Work (_____) _____ Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name _____ Relationship _____
Home Phone (_____) _____ Work Phone (_____) _____

DENTAL HISTORY

Reason for today's visit _____	Burning sensation on tongue <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth breathing <input type="checkbox"/> Yes <input type="checkbox"/> No
Former Dentist _____	Chew on one side of mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Mouth pain, brushing <input type="checkbox"/> Yes <input type="checkbox"/> No
City/State _____	Cigarette, pipe, or cigar smoking <input type="checkbox"/> Yes <input type="checkbox"/> No	Orthodontic treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental visit _____	Clicking or popping jaw <input type="checkbox"/> Yes <input type="checkbox"/> No	Pain around ear <input type="checkbox"/> Yes <input type="checkbox"/> No
Date of last dental X-rays _____	Dry mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Periodontal treatment <input type="checkbox"/> Yes <input type="checkbox"/> No
Place a mark on "yes" or "no" to indicate if you have had any of the following:	Fingernail biting <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to cold <input type="checkbox"/> Yes <input type="checkbox"/> No
Bad breath <input type="checkbox"/> Yes <input type="checkbox"/> No	Food collection between the teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to heat <input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding gums <input type="checkbox"/> Yes <input type="checkbox"/> No	Foreign objects <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity to sweets <input type="checkbox"/> Yes <input type="checkbox"/> No
Blisters on lips or mouth <input type="checkbox"/> Yes <input type="checkbox"/> No	Grinding teeth <input type="checkbox"/> Yes <input type="checkbox"/> No	Sensitivity when biting <input type="checkbox"/> Yes <input type="checkbox"/> No
	Gums swollen or tender <input type="checkbox"/> Yes <input type="checkbox"/> No	Sores or growths in your mouth <input type="checkbox"/> Yes <input type="checkbox"/> No
	Jaw pain or tiredness <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you floss? _____
	Lip or cheek biting <input type="checkbox"/> Yes <input type="checkbox"/> No	How often do you brush? _____
	Loose teeth or broken fillings <input type="checkbox"/> Yes <input type="checkbox"/> No	

HEALTH HISTORY

Physician's Name _____

Date of last visit _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine), Pondimin (fenfluramine) and Redux (dexfenfluramine). ☐ Yes ☐ No

Place a mark on "yes" or "no" to indicate if you have had any of the following:

AIDS/HIV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Respiratory Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Fainting or dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Arthritis, Rheumatism	<input type="checkbox"/> Yes <input type="checkbox"/> No	Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Scarlet Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Heart Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headaches	<input type="checkbox"/> Yes <input type="checkbox"/> No	Shortness of Breath	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sinus Trouble	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Heart Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No
Back Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis Type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Diet	<input type="checkbox"/> Yes <input type="checkbox"/> No
Bleeding abnormally, with extractions or surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No	Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Feet or Ankles	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swollen Neck Glands	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemical Dependency	<input type="checkbox"/> Yes <input type="checkbox"/> No	Jaw Pain	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Circulatory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Congenital Heart Lesions	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumor or growth on head or neck	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cortisone Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Ulcer	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cough, persistent or bloody	<input type="checkbox"/> Yes <input type="checkbox"/> No	Nervous Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	Venereal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pacemaker	<input type="checkbox"/> Yes <input type="checkbox"/> No	Weight Loss, unexplained	<input type="checkbox"/> Yes <input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No		
		Radiation Treatment	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Do you wear contact lenses? ☐ Yes ☐ No

Women:

Are you pregnant? ☐ Yes ☐ No

Due date _____

Are you nursing? ☐ Yes ☐ No

Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis:

Pharmacy Name _____

Phone (_____) _____

ALLERGIES

☐ Aspirin

☐ Local Anesthetic

☐ Barbiturates (Sleeping pills)

☐ Penicillin

☐ Codeine

☐ Sulfa

☐ Iodine

☐ Other _____

☐ Latex

UPDATES (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions? _____

Are you taking any new medications? _____ If so, what? _____

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Davidson Cosmetic & Family Dentistry
FINANCIAL POLICIES & INSURANCE PROCEDURES

We are committed to providing the best dental care available to you. In order to do so, we need your partnership and your clear understanding of our financial policies. Therefore, we ask that you read and understand the following:

- 1.) Dr. Wilhite and staff are committed to having a medical care relationship with you, separate from any contractual agreements with insurance companies. Because you are the recipient of services, all charged are your responsibility and are due at the time of service. For your convenience we accept Cash, Check, Visa & MasterCard. In the event that we receive a returned check, a \$25.00 fee will be added to your account balance.
- 2.) Your insurance is a unique contract between you, and your employer (if applicable), and your insurance company. Please note: not all services are covered by all insurance policies. This is not to be confused with Dr. Wilhite's determination of which services are medically necessary or appropriate.
- 3.) We require a down payment of \$100.00 per treatment hour in order to schedule future treatment appointments.

Insurance Procedures

As a courtesy for you, for each visit to our office we will file a claim with all requested documentation to your insurance provider on your behalf. We will provide this service for both your primary insurance and, when applicable, for your secondary insurance provider. In order to process your claim for you, we must have the necessary information which includes: Insurance carrier's name, address and phone number. For our records we will make a copy of the front and back of your insurance card. If you are not the subscriber listed on the card – we will also need the subscriber's name, birth date, employer, group number and identification.

Note: Not all services are covered by all insurance policies. If you have any questions about what procedures your insurance will cover, we will gladly contact your insurance provider to obtain this information. Also, if after your office visit you fail to receive a check from your insurance company within 3-4 weeks, please call our office, as we will contact your insurance company and investigate the delay.

UNDERSTANDING AND AGREEMENT

I _____ have read the financial policy and insurance information. I understand and accept that, regardless of my insurance status, I am responsible for payment of services provided by Dr. Michael B. Wilhite of Davidson Cosmetic & Family Dentistry and that the charged are due at the time services are rendered.

Patient Name – Please Print

Signature of Patient or Responsible Party

Date: _____

MISSED APPOINTMENT POLICY

We want our patients to know how much we value your business. In an effort to provide the highest quality of dental care for all of our clients, we require **2 FULL BUSINESS DAYS NOTICE** to reschedule an upcoming appointment.

Our office understands that sometimes emergency situations arise and are unavoidable in which we will handle each circumstance on an individual basis. We would like our patients to understand that missed or broken appointments are hurtful in many ways. First, they delay your treatment and our ability to keep your oral health at optimum levels. Second, they may prevent another patient, who needs treatment, from getting the necessary care in a timely manner. With this in mind we want you to be informed of our appointment policy so that there are no misunderstandings in the future.

Each patient may miss one appointment due to emergency without a 48 hour notice in a 12 month period. After a second broken appointment occurs we will not pre-appoint you for any future appointments without a credit card on file, in which your card will be charged \$75.00 per hour for appointments that you schedule and break without giving a 48 hour notice. If you arrive 15 minutes or more after your appointment time we will need to reschedule your appointment.

We, make every effort to value your time and we schedule your appointment time just for you. We truly appreciate your courtesy of giving us 48 hours notice if you have a conflict with your appointment and need to schedule a different time. We are committed to your oral health. Keeping your scheduled appointments allows us to be partners in your dental care.

It is our philosophy to continue to put our patients first and to make each experience a positive one. Thank you for allowing us to share our missed appointment policy with you. Please let us know if you have any questions.

Thank you in advance for your cooperation,
Michael B. Wilhite, DMD & the Staff of Davidson Cosmetic & Family Dentistry.

Patient Name – Please Print

Signature of Patient or Responsible Party

Date: _____

Medical Information Release Form
(HIPAA Release Form)

Name: _____

Date of Birth: ____/____/____

Release of Information

I _____ authorize the release of information including diagnosis, records, and payment to (check all that apply):

☐ Parent _____

☐ Spouse _____

☐ Child _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of information will remain in effect until terminated by me in writing.

Signed: _____

Date: ____/____/____

Witness: _____

Date: ____/____/____