

WELCOME

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral

health. Please fill out these forms completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR. MRS. MS. DR.

I prefer to be called: _____ Male Female

Birthdate: ___ / ___ / ___ Age: ___ SS#: _____

Home Address: _____
APT / CONDO*

CITY STATE ZIP

Single Married Divorced Widowed Separated

Home#: _____ Pager / Other#: _____

WK#: _____ Ext _____ DL#: _____

Employer: _____

Employer's Address: _____

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

3 DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthday: ___ / ___ / ___ Insured's SS#: _____

Insured's Employer: _____

I hereby assign directly all insurance benefits, if any, otherwise payable to me for services rendered to Dr. Derek H. Wall. I understand that I am financially responsible for all charges whether or not paid by insurance. I understand that there will be service charges added to balances older than 90 days and that, should my account be turned over for outside collection, there will be an added collection fee. 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.

Signature: _____ Date: _____

In the event of an emergency, is there someone who lives near you that we should contact?

Their Name: _____ Relation: _____

WK#: _____ HM#: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

WK#: _____ Ext _____ SS#: _____

Birthdate: _____ DL#: _____

Person Responsible for Account: _____

WK#: _____ Ext _____ HM#: _____

Billing Address: _____
Zip

Relationship _____ SS#: _____

Employer: _____ DL#: _____

4 MEDICAL HISTORY

Do you have a personal physician No Yes

Physician's Name: _____

Phone #: _____ Date of last visit: _____

CONTINUED ON BACK OF FORM

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MEDICAL HISTORY *continued*

Your current physical health is Good Fair Poor

Are you currently under the care of a physician? No Yes

Please explain _____

Are you taking any prescription / over-the-counter drugs? No Yes

Please list each one _____

For Women Are you taking birth control pills? No Yes

Are you pregnant? No Yes Week # _____

Are you nursing? No Yes

Have you ever had any of the following diseases or medical problems?

- | | |
|---------------------------------|---|
| Y N Heart Attack / Stroke | Y N Psychiatric Problems |
| Y N Cancer / Chemotherapy | Y N Epilepsy / Seizures / Fainting Spells |
| Y N Heart Murmur | Y N Diabetes / Tuberculosis (TB) |
| Y N Rheumatic Fever | Y N Drug / Alcohol Abuse |
| Y N HIV+ / AIDS | Y N Venereal Disease |
| Y N Heart Surgery / Pacemaker | Y N Hemophilia / Abnormal Bleeding |
| Y N Shingles | Y N Ulcers / Colitis |
| Y N Mitral Valve Prolapse | Y N Congenital Heart Defect |
| Y N Kidney Problems | Y N Anemia / Radiation Treatment |
| Y N Artificial Bones / Joints | Y N Asthma / Arthritis |
| Y N Artificial Valves | Y N Difficulty Breathing |
| Y N Sinus Problems | Y N Hospitalized for Any Reason |
| Y N High / Low Blood Pressure | Y N Hepatitis |
| Y N Fever Blisters | Y N Blood Transfusion |
| Y N Severe / Frequent Headaches | Y N Emphysema / Glaucoma |

Please list any serious medical condition(s) that you have ever had:

Are you allergic to any of the following drugs?

- | | | |
|------------------|------------------------|-----------|
| Y N Penicillin | Y N Tetracycline | Y N Latex |
| Y N Aspirin | Y N Dental Anesthetics | Y N Other |
| Y N Erythromycin | Y N Codeine | |

Please list any other drugs that you are allergic to: _____

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DENTAL HISTORY

Why have you come to the dentist today?

Are you currently in pain? No Yes

Have you ever had a serious / difficult problem associated with any previous dental work? No Yes

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)?

No Yes

Your current dental health is Good Fair Poor

Do you like your smile? No Yes Do your gums ever bleed No Yes

How many times a week do you floss? ____ a day do you brush? ____

Type of bristles? Hard Medium Soft



I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment

Signature _____ Date _____

Payment is due in full at the time of treatment unless prior arrangements have been approved.



Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

THERE WILL BE A SERVICE CHARGE FOR BROKEN APPOINTMENTS. IF A CHANGE OF SCHEDULE IS NECESSARY, WE REQUIRE A 48 HOUR NOTICE.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

MEDICAL HISTORY UPDATE

1. Date _____ Comments _____ Signature _____

2. Date _____ Comments _____ Signature _____

Derek H. Wall D.D.S. P.A.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

"You may refuse to sign this acknowledgement"

_____ have received a copy of
the office's Notice of Privacy Practices

(Please print name)

(Signature)

(Date)

_____ For Office Use Only _____

We attempted to obtain written acknowledgement of receipt of our
Notice of Privacy Practices but
acknowledgement could not be obtained because

_____ Individual refused to sign

_____ Communications barrier prohibited obtaining the
acknowledgement

_____ An emergency situation prevented us from obtaining
acknowledgement

_____ Other (please specify)
