



**Patient Information**

Name: \_\_\_\_\_  
Last First Middle  
E-Mail Address: \_\_\_\_\_ Gender: Male \_\_\_\_\_ Female \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Street City State Zip  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Driver's License or ID Number: \_\_\_\_\_  
MM/DD/YYYY

**Responsible Party Information (If Patient is a Dependent)**

Name: \_\_\_\_\_  
Last First Middle  
Relationship to Patient: \_\_\_\_\_ E-Mail Address: \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Street City State Zip  
Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_-\_\_\_\_-\_\_\_\_ Driver's License or ID Number: \_\_\_\_\_  
MM/DD/YYYY

**Dental Insurance Information (Please Provide a Copy of Your Card)**

Name of Primary Policy Holder: \_\_\_\_\_  
Last First Middle  
Primary Policy Holder's Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Primary Policy Holder's SS/ Member ID Number: \_\_\_\_-\_\_\_\_-\_\_\_\_  
MM/DD/YYYY  
Primary Policy Holder's Employer: \_\_\_\_\_ Rank: \_\_\_\_\_  
Insurance Company Name: \_\_\_\_\_ Group Number: \_\_\_\_\_ Insurance Company Phone: (\_\_\_\_) \_\_\_\_\_  
Insurance Company Address: \_\_\_\_\_  
Street City State Zip

**Emergency Contact Information**

Local Friend or Relative not Living With You: \_\_\_\_\_ Emergency Contact Phone: (\_\_\_\_) \_\_\_\_\_  
Emergency Contact Address: \_\_\_\_\_  
Street City State Zip

**Getting to Know You**

Why did you select our office? \_\_\_\_\_ Whom May we thank for referring you? \_\_\_\_\_  
Is another member of your family already a patient with our practice? \_\_\_\_\_  
When was your last dental visit? \_\_\_\_\_  
When was the last time you had complete dental x-rays taken? \_\_\_\_\_ Have you ever had any teeth removed? \_\_\_\_\_  
How long have these teeth been missing? \_\_\_\_\_  
How Have these teeth been replaced?  Bridge  Partial  Denture  Implants  They have not been replaced

**FOR ALL PATIENTS**

I authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the dental care of the patient above, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office.

SIGNATURE OF RESPONSIBLE PARTY

RELATIONSHIP TO PATIENT

DATE



HEALTH HISTORY

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Birth Date \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Age \_\_\_\_\_ Gender:  M  F

Please list all medical problems you are currently being treated for: \_\_\_\_\_

Please list all of your previous surgeries: \_\_\_\_\_

Please list any drug, food or latex allergies: \_\_\_\_\_

Please list your current medications: including aspirin or any other over the counter medications: \_\_\_\_\_

DO YOU HAVE, OR HAVE YOU EVER HAD....

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis           | <input type="checkbox"/> Yes <input type="checkbox"/> No Bleeding/blood clot problems         |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart attack            | <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco use            | <input type="checkbox"/> Yes <input type="checkbox"/> No Anesthetic problems                  |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Irregular heart beat    | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes               | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/seizures                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Pacemaker/defibrillator | <input type="checkbox"/> Yes <input type="checkbox"/> No Liver disease          | <input type="checkbox"/> Yes <input type="checkbox"/> No Glaucoma/eye problems                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart murmur            | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney disease         | <input type="checkbox"/> Yes <input type="checkbox"/> No Ulcers/gastric reflux                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Angioplasty/bypass      | <input type="checkbox"/> Yes <input type="checkbox"/> No Thyroid disease        | <input type="checkbox"/> Yes <input type="checkbox"/> No History of alcohol or drug abuse     |
| <input type="checkbox"/> Yes <input type="checkbox"/> No High blood pressure     | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic fever        | <input type="checkbox"/> Yes <input type="checkbox"/> No Currently pregnant/nursing           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Heart valve replacement | <input type="checkbox"/> Yes <input type="checkbox"/> No Immune system problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hip/knee/joint replacement           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis/jaundice     | <input type="checkbox"/> Yes <input type="checkbox"/> No Blood thinners                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of breath     | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Bone density medication              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema/COPD          | <input type="checkbox"/> Yes <input type="checkbox"/> No Chemotherapy           | <input type="checkbox"/> Yes <input type="checkbox"/> No Require antibiotics prior to surgery |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Sleep apnea             | <input type="checkbox"/> Yes <input type="checkbox"/> No Radiation therapy      |   |

DENTAL HISTORY (PLEASE CHECK ALL THAT APPLY):

- |  |                                       |   |  |                                      |
|--|---------------------------------------|---|--|--------------------------------------|
| <input type="checkbox"/> Routine care only | <input type="checkbox"/> Orthodontics | <input type="checkbox"/> Jaw/tooth trauma | <input type="checkbox"/> TMJ problems    | <input type="checkbox"/> Jaw surgery |
| <input type="checkbox"/> Gum disease       | <input type="checkbox"/> Cancer       | <input type="checkbox"/> Mouth sores      | <input type="checkbox"/> Dental implants | <input type="checkbox"/> Dentures    |

Please list anything else about your medical or dental history we should know: \_\_\_\_\_

Signature-Patient/Guardian

Dr's initials

UPDATED: \_\_\_\_\_ DATE: \_\_\_\_\_



DENTAL INSURANCE POLICY

Woodmen Dental Group proudly accepts most dental insurance plans. We file all dental insurance claims as a patient courtesy. In the event of a treatment plan, we create a reasonable estimate of patient co-payments and insurance contributions. This estimate is based on contracted insurance rates, the general breakdown of benefits obtained through the insurance verification process and our knowledge of common insurance exclusions. **This estimate is not a guarantee of insurance payment. All benefit determinations are at the discretion of the insurance company and are not determined until after a claim is submitted.** We provide treatment estimates as a courtesy in order to minimize the total out-of-pocket cost due by patient. **All estimated patient co-payments are due on or before time of service.**

**Patient is responsible for any remaining account balance resulting from insurance nonpayment or underpayment. A statement will be mailed to you regarding this balance. Payment is due immediately upon receipt.**

-----PATIENT ACKNOWLEDGMENT AND AUTHORIZATION-----

I understand and agree to the Dental Insurance Policy stated above. I authorize all my insurance companies to make payment directly to Woodmen Dental Group. This assignment will remain in effect unless revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance company. Further, I authorize the release of any patient information necessary to process these claims.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

APPOINTMENT DEPOSIT REQUIREMENT

**Woodmen Dental Group requires a minimum \$50.00 deposit for all appointments requiring 90 minutes or more of estimated chair-time and for all appointments with a total treatment cost of \$300.00 or more.** The deposit operates as a credit on the patient account towards the total patient portion due on or before time of service. Woodmen Dental Group requires this deposit because our providers and dental assistants reserve the appointment time specifically for you at the exclusion of other patients. **The deposit requirement is subject our Cancellation Policy.**

The deposit requirement is reserved only for those patients choosing not to pre-pay for their services in full when scheduling the appointment.

I understand and agree.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

CANCELLATION POLICY

Woodmen Dental Group makes an effort to see patients on time in order to give patients they care they deserve. Therefore, we ask that you **please give 24 hours notice if you are unable to keep your scheduled appointment. We reserve the right to charge a \$50.00 cancellation fee for lack of proper notice.** We will make exceptions in the event of reasonable emergencies.

I understand and agree.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICES

I, \_\_\_\_\_, have had the opportunity to review Woodmen Dental Group's Notice of Privacy Practices (the entire legal notice is displayed at the front desk).

Signature: \_\_\_\_\_ Date: \_\_\_\_\_