



PATIENT INFORMATION:			
LAST NAME:	FIRST NAME:	MI:	
NAME YOU PREFER:	DATE OF BIRTH:	SOCIAL SECURITY #:	
ADDRESS:	CITY:	STATE:	ZIP:
HOME PHONE:	MOBILE PHONE:	WORK PHONE:	EXT:
EMAIL:			
GENDER: M: <input type="checkbox"/> F: <input type="checkbox"/> O: <input type="checkbox"/>		MARRIED/DOMESTIC PARTNER: Y: <input type="checkbox"/> N: <input type="checkbox"/>	
HOW DID YOU HEAR ABOUT US? DRIVE BY: <input type="checkbox"/> SOCIAL MEDIA/WEBSITE: <input type="checkbox"/> INSURANCE: <input type="checkbox"/> FAMILY/FRIEND: <input type="checkbox"/>			
ARE ANY OTHER MEMBERS OF YOUR HOUSEHOLD A PATIENT WITH US? Y: <input type="checkbox"/> N: <input type="checkbox"/> NAME:			

PRIMARY INSURANCE:	
INSURANCE COMPANY NAME:	
PRIMARY SUBSCRIBERS NAME(IF DIFFERENT FROM THE PATIENT):	DATE OF BIRTH:
RELATIONSHIP TO SUBSCRIBER: SPOUSE: <input type="checkbox"/> PARENT: <input type="checkbox"/> OTHER: <input type="checkbox"/>	SUBSCRIBERS SOCIAL SECURITY:
ID NUMBER:	GROUP NUMBER: EFFECTIVE DATE:
CLAIMS ADDRESS:	
CLAIMS PHONE NUMBER:	

SECONDARY INSURANCE:	
INSURANCE COMPANY NAME:	
PRIMARY SUBSCRIBERS NAME(IF DIFFERENT FROM THE PATIENT):	DATE OF BIRTH:
RELATIONSHIP TO SUBSCRIBER: SPOUSE: <input type="checkbox"/> PARENT: <input type="checkbox"/> OTHER: <input type="checkbox"/>	SUBSCRIBERS SOCIAL SECURITY:
ID NUMBER:	GROUP NUMBER: EFFECTIVE DATE:
CLAIMS ADDRESS:	
CLAIMS PHONE NUMBER:	

PAYMENT IS DUE AT TIME OF SERVICE. IF PATIENT IS COVERED BY INSURANCE, THE INSURANCE COMPANY WILL BE BILLED. IT IS YOUR RESPONSIBILITY, HOWEVER, TO PAY YOUR PORTION AT TIME OF SERVICE. IF THE NECESSARY, PLEASE DISCUSS OTHER FINANCIAL ARRANGEMENTS WITH OUR BILLING OFFICE.

EMERGENCY CONTACT:		
LAST NAME:	FIRST NAME:	SPOUSE/PARTNER: Y: <input type="checkbox"/> N: <input type="checkbox"/>
PRIMARY PHONE:	SECONDARY PHONE:	PATIENT HERE: Y: <input type="checkbox"/> N: <input type="checkbox"/>

I ACKNOWLEDGE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY INSURANCE. THE UNDERSIGNED AGREES TO PAY FOR ALL COST AND EXPENSES. I HEREBY AUTHORIZE THE OFFICE TO RELEASE INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS.

SIGNATURE:	
PATIENT SIGNATURE (OR GUARDIAN):	DATE:

NAME _____ DOB _____

PRIMARY PHYSICIAN INFORMATION

PHYSICIAN: _____ TELEPHONE: _____

CLINIC/FACILITY: _____

MEDICAL HISTORY

GENERAL HEALTH: EXCELLENT GOOD FAIR POOR

- y n UNDER A PHYSICIAN'S CARE NOW?
- y n ANY HOSPITALIZATION IN THE PAST 5 YEARS? _____
- y n ANY SERIOUS ILLNESSES/SURGERIES? _____
- y n USE TOBACCO IN ANY FORM? IF YES, TYPE: _____
- y n IS PRE-MEDICATION REQUIRED BEFORE DENTAL VISITS DUE TO HEART CONDITION OR ARTIFICIAL JOINT?
- y n TAKING ANY PRESCRIPTION OR DAILY OTC MEDICATIONS/DRUGS? IF YES, LIST DETAILS IN THE MEDICATION SECTION.

FEMALE PATIENTS: y n CURRENTLY NURSING? y n CURRENTLY PREGNANT? DUE DATE: _____

DO YOU KNOW OF ANY REASON WHY ROUTINE DENTAL PROCEDURES MIGHT POSE A RISK TO YOU, OUR STAFF, OR OTHER PATIENTS? y n
IF YES, PLEASE DESCRIBE: _____

IS THERE ANYTHING IMPORTANT ABOUT YOUR MEDICAL CONDITION WE HAVE NOT ASKED? y n IF YES, PLEASE DESCRIBE: _____

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> ACID REFLUX | <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEAD INJURIES | <input type="checkbox"/> PREGNANCY |
| <input type="checkbox"/> ADHD | <input type="checkbox"/> CANCER/MALIGNANCY | <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> CHEMOTHERAPY | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> RADIATION |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> CHEMICAL DEPENDENCY | <input type="checkbox"/> HEART MURMUR | <input type="checkbox"/> RESPIRATORY DISEASE |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> COUGH, PERSISTENT | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANXIETY | <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> SINUS PROBLEMS |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> DIZZINESS/FAINTING | <input type="checkbox"/> JAW PAIN | <input type="checkbox"/> THYROID CONDITION |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> EPILEPSY/SEIZURES | <input type="checkbox"/> LIVER PROBLEMS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> EXCESSIVE BLEEDING | <input type="checkbox"/> MENTAL DISORDER | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> AUTISM/ASPERGER'S | <input type="checkbox"/> FREQUENT HEADACHES | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> VENEREAL DISEASE |
| <input type="checkbox"/> BLOOD DISEASE | <input type="checkbox"/> HEARING PROBLEMS | <input type="checkbox"/> OTHER — PLEASE LIST: _____ | |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

NONE

- | | | | |
|---|----------------------------------|---|---|
| <input type="checkbox"/> ASPIRIN | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE | <input type="checkbox"/> SLEEPING PILLS |
| <input type="checkbox"/> ANESTHETIC — LOCAL | <input type="checkbox"/> DAIRY | <input type="checkbox"/> METAL SENSITIVITY | <input type="checkbox"/> SULFA DRUGS |
| <input type="checkbox"/> BARBITURATES | <input type="checkbox"/> LATEX | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |
| <input type="checkbox"/> OTHER — PLEASE LIST: _____ | | | |

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY)

NONE

- | | | | |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY | <input type="checkbox"/> DAILY ASPIRIN | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN | <input type="checkbox"/> NITROGLYCERIN | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW) | | | |

DRUG NAME	DOSAGE	REASON PRESCRIBED

PREVIOUS DENTIST INFORMATION

DENTIST: _____ TELEPHONE: _____
 CLINIC/FACILITY: _____
 ADDRESS: _____

 CITY ST ZIP CODE

DENTAL HISTORY

ORAL HEALTH: EXCELLENT GOOD FAIR POOR

DATE OF LAST DENTAL VISIT: _____ TREATMENT TYPE: _____

- y n ARE YOU CURRENTLY HAVING DENTAL DISCOMFORT? IF YES, EXPLAIN: _____
- y n ANY UNHAPPY/UNPLEASANT DENTAL EXPERIENCES? IF YES, EXPLAIN: _____
- y n ANY INJURIES TO MOUTH/TEETH/HEAD? IF YES, EXPLAIN: _____
- y n ANY MISSING TEETH OTHER THAN WISDOM TEETH OR ORTHODONTIC EXTRACTIONS?
- y n HAVE MISSING TEETH BEEN REPLACED?
- y n ORTHODONTIC APPLIANCES NOW OR IN THE PAST?
- y n GUMS BLEED WHEN BRUSHING OR FLOSSING?
- y n CONCERNED ABOUT GUM DISEASE? HISTORY OF GUM DISEASE? y n
- y n ANY CONCERNS ABOUT THE APPEARANCE OF YOUR TEETH?
- y n DOES IT HURT TO BITE OR CHEW?
- y n DO YOU CLENCH OR GRIND YOUR TEETH? IF SO, DO YOU WEAR A NIGHT GUARD OR SPLINT? y n
- y n DO YOU WANT TO BECOME A REGULAR CONTINUING CARE PATIENT IN OUR PRACTICE?
- y n DO YOU WANT YOUR MOUTH PROPERLY RESTORED AND PAIN FREE?
- y n DOES ANY TYPE OF DENTAL TREATMENT MAKE YOU NERVOUS? IF YES, PLEASE EXPLAIN BELOW:

THE MOST IMPORTANT CONCERNS REGARDING MY DENTAL TREATMENT ARE:

WHAT FACTORS ARE MOST IMPORTANT FOR YOUR SATISFACTION WITH OUR OFFICE?

ANY ADDITIONAL CONCERNS/COMMENTS?

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

WE ARE COMMITTED TO PROVIDING YOU WITH THE HIGHEST QUALITY DENTAL CARE AND UP-TO-DATE INFORMATION SO THAT YOU MAY FULLY PARTICIPATE IN MAINTAINING THE BEST POSSIBLE ORAL HEALTH. OUR FINANCIAL POLICY IS INTENDED TO FACILITATE EXCELLENT SERVICE TO YOU WHILE MINIMIZING OUR ADMINISTRATIVE COSTS.

- WE REQUIRE PAYMENT IN FULL AT TIME OF SERVICE
- FOR PATIENTS WHO HAVE INSURANCE, THE ENTIRE ESTIMATED CO-PAY IS DUE AT THE TIME OF SERVICE.
- WITH THE INFORMATION YOUR INSURANCE COMPANY PROVIDES US, WE WILL DO OUR BEST TO PROVIDE YOU AN ESTIMATE OF YOUR CO-PAY PRIOR TO YOUR APPOINTMENT. PLEASE READ YOUR INSURANCE BENEFIT BOOKLET AND UNDERSTAND ALL WAITING PERIODS, FREQUENCY LIMITATIONS, AGE LIMITS ANY EXCEPTIONS, AND EXCLUSIONS. IF YOU ARE 'DOUBLE COVERED' WITH 2 INSURANCE COMPANIES, BE AWARE OF A 'DUPLICATION CLAUSE' AND VERIFY WHETHER OR NOT YOUR SECONDARY INSURANCE HAS STANDARD COORDINATION OF BENEFITS OR NOT.
- AS A COURTESY, WE GLADLY PROCESS YOUR INSURANCE CLAIMS AND ESTIMATE THE AMOUNT NOT COVERED BY YOUR INSURANCE. ALL INCURRED CHARGES ARE ULTIMATELY THE RESPONSIBILITY OF THE PATIENT REGARDLESS OF INSURANCE COVERAGE.
- RETURNED CHECKS FOR INSUFFICIENT FUNDS OR CLOSED ACCOUNTS ARE SUBJECT TO A \$25.00 FEE. IF A CHECK IS RETURNED, CASH, VISA, MASTERCARD OR CARECREDIT WILL BE THE ONLY ACCEPTED FORM OF PAYMENT.
- WE MAKE EVERY EFFORT TO HONOR ALL TIME COMMITMENTS AND REQUEST THAT YOU EXTEND THE SAME COURTESY TO US. WE KNOW THAT ON OCCASION, CIRCUMSTANCES ARISE THAT CAUSE A DELAY IN YOUR SCHEDULE. IF SCHEDULED APPOINTMENTS CANNOT BE KEPT, PLEASE NOTIFY OUR OFFICE AT LEAST 24 HOURS IN ADVANCE. A 40.00 FEE WILL BE CHARGED FOR A CANCELLATION WITHOUT PROPER NOTIFICATION

ALTHOUGH WE ARE UNABLE TO ARRANGE PAYMENT PLANS THROUGH OUR OFFICE, DR. WAGNER OFFERS A CREDIT PROGRAM THROUGH A THIRD PARTY AGENCY, CARECREDIT. CARECREDIT IS A LOW, AND IN SOME CASES, ZERO-INTEREST CREDIT CARD, WHICH PROVIDES A FLEXIBLE PAYMENT PLAN AND CAN ALSO BE USED FOR A VARIETY OF OTHER HEALTH CARE SERVICES. MORE INFORMATION IS AVAILABLE AT WWW.CARECREDIT.COM OR BY STOPPING BY OUR OFFICE TO PICK UP A BROCHURE.

PAYMENT OPTIONS:

- CASH
- VISA/MASTERCARD
- CARECREDIT

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY OF WAGNER DENTAL CARE

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.



OUR COMMITMENT HERE AT WAGNER FAMILY DENTAL PC IS TO SERVE OUR CUSTOMERS WITH PROFESSIONALISM AND CARING, BEING SURE AT ALL TIMES TO PROTECT THE PRIVACY AND SECURITY OF ALL PROTECTED HEALTH INFORMATION.

DURING THE COURSE OF SERVING YOUR INTERESTS IT MAY BE NECESSARY TO SHARE INFORMATION WITH OTHER HEALTH CARE PROVIDERS OR BUSINESS ASSOCIATES. THE FOLLOWING ARE EXAMPLES OF INSTANCES WHERE INFORMATION MAY BE SHARED:

- DURING TREATMENT, WE MAY FIND IT NECESSARY TO ACQUIRE LAB ANALYSIS
- FOR PAYMENT PURPOSES, WE MAY USE THE SERVICES OF A BILLING SERVICE
- DURING DENTAL CARE OPERATIONS, WE MAY NEED A SECOND OPINION
- REFERRAL TO SPECIALIST MAY REQUIRE A SHARING OF INFORMATION

WE ARE COMMITTED TO OBEYING ALL FEDERAL, STATE AND LOCAL LAWS AND REGULATIONS REGARDING PRIVACY PRACTICES. IF ANY OTHER USES OR DISCLOSURES THAT THE ONES LISTED ABOVE ARE NEEDED, INFORMATION WILL ONLY BE RELEASED WITH THE WRITTEN AUTHORIZATION OF THE INDIVIDUAL IN QUESTION. THIS WRITTEN AUTHORIZATION MAY BE REVOKED AT ANY TIME BY THE INDIVIDUAL, AS PROVIDED FOR BY LAW.

IF YOU HAVE ANY QUESTIONS OR COMMENTS REGARDING YOU PROTECTED HEALTH INFORMATION, PLEASE CONTACT OUR OFFICE AT (503) 239-5115.

I HAVE READ AND UNDERSTAND THE ABOVE NOTICE OF PRIVACY PRACTICES.

SIGNATURE: _____ DATE: _____
(PATIENT OR LEGAL GUARDIAN)

PRINTED NAME: _____