Welcome

Patient Information

Patient Name:_____ Date of Birth:_____ Age:_____ Sex:____

Home Address:_____ City:_____ State:_____ Zip:_____

Home #:_____ Mobile#:_____ Email:_____

SSN#:_____ (We ask that you fill this out for insurance purposes)

Insurance Information

Please provide us with a copy at the time of your appointment

Subscriber Name:_____ Date of Birth:_____ SSN:_____

Subscriber Address if different:_____

Insurance Name:_____

Do you have a Secondary Insurance Coverage? Yes or No (if no, please skip)

Subscriber Name:_____ Date of Birth:_____ SSN:_____

Subscriber Address if different:_____

Insurance Name:_____

Emergency Contact

In case of an emergency, who should we contact?

Name:_____ Relationship:_____

Contact cell #:_____ Contact Work #:_____

Physician Information

Name of your Physician:_____ Phone #:_____

Date of last visit:_____

In case of an emergency, I authorize Dr. Wyman's office to refer me to the nearest hospital for treatment.

Sign:_____ Today's Date:_____

Dental Health Questionnaire

Do you have difficulty chewing? Yes/No

Do your gums bleed when you floss? Yes/ No

Do you have periodontal disease? Yes/ No

Do you smoke? Y/N If so, do you also chew tobacco? Yes/No

Are your teeth sensitive? Yes/No

Do you find yourself having a dry mouth? Yes/No

Do any of your teeth have pain when you eat sweets, hot or cold liquids, chewing? Yes/No

Does your jaw click when opening? Yes/No

Do you have a gag reflex? Yes/No

Do you find your jaw locking in place? Yes/No

Do you wake up with headaches or jaw pain? Yes/No

Does your physician require you to pre-medicate prior to a dental visit? Yes or No

If you do pre-medicate, please explain:_____

Do you have a history of alcohol or drug abuse? Yes/No

When was your last dental visit? _____

When was the last time you had a full mouth of x-rays done? _____

What is your main concern for today's visit?

_____

_____

Are you pregnant? If so, please provide us with your delivery date: _____

Are you nursing? Y/N Have you reached menopause? Y/N

Do you take Hormones? Y/N Are you taking any contraceptives? Y/N

Patient Signature:_____ Date:_____

Medical History

During the last 12 months, have you taken any of the following: (Please Circle)

Antibiotics	Sulfa Drugs	Anticoagulants (Coumadin)
Tranquilizers	Nitroglycerin	Digitalis/ Heart Trouble Drugs
Aspirin	Cortisone (Steroids)	High Blood Pressure Drugs
Natural Remedies	Non-prescription drugs	Bisphosphonates (Osteoporosis)
Supplements		

If you have Allergies (Please Circle)

Local Anesthetics	Penicillin or other Sulfa Drugs	Aspirin
Barbiturates, sedatives	Acetaminophen	Ibuprofen
Narcotics/ Codeine/Demerol	Latex	Metals
Seasonal		

Others not listed : _____

Circle below if applicable

Heart Problems	Blood Problems	Chest Pain
Shortness of Breath	High Blood Pressure	Heart Murmur
Heart Valve Issues	Pacemaker	Intestinal Problems
Ulcers	Anemia	Bone or Joint Problems
Arthritis	Diabetes	Fainting/Dizzy Spells
Joint Replacement	Back or neck pain	Strokes
Cancer/Tumor	Thyroid Problems	Herpes or other STD
HIV Positive/ Aids	Glaucoma	Blood Transfusion
Rheumatic Fever	Epilepsy	Abnormal Bleeding
Frequent Nosebleeds	Liver Issues	Migraines
Tuberculosis/ Respiratory	Hepatitis, Jaundice	Kidney/ Bladder
Sleep Apnea	Asthma	

Do you use recreational drugs? Yes/No How often if so? _____

Do you drink alcohol? Yes/No How often if so? _____

Do you have any disease, conditions, or problems not listed previously that you feel we should know about? If so, please elaborate:

_____

_____

Please list your current medications with quantity taken:

_____ _____

_____ _____

_____ _____

_____ _____

Patient Signature:_____ Date:_____

Office Policy Regarding Insurance

Acknowledgement

I acknowledge that I have received and understood this practice's policy regarding insurance. The notice provides a detailed description of my responsibilities regarding my insurance coverage. I understand that my portion may only be an estimate and not a guarantee of what my insurance may or may not contribute with each claim.

In addition, I understand that this practice's policy is to use composite resin fillings on anterior and posterior teeth only.

I accept responsibility for payment of all charges for services, whether I have insurance or not. I also understand that payment may be due at the time of service.

I authorize Dr. Wyman to furnish copies of my records with my insurance carrier and assign Dr. Wyman any benefits due to my insurance for his services.

I understand that this office will charge 1.5% of the current balance or 18% per annum, on any account over 60 days old. I agree to be charged $2.00 minimum on such account. I understand that this will take place if we have not received any payments after 60 days from first statement sent.

Appointment & Cancellation Policy

Our office will make every attempt to schedule your appointment within reasonable time. However, should you need to reschedule or cancel your appointment, please contact our office within 48 hours prior to your appointment. Failure to provide at least 24 hours' notice will result in a $50 fine. In fairness to other patients who are waiting for an appointment, we allow up to 3 missed appointments before we terminate care.

I have received and understood this practice's Notice of Privacy Practices written in plain language. The notice provides a detailed account of the uses and disclosures of my personal health information, my individual rights and how I exercise those rights and the practices legal duties with respect to my rights.

Printed Name: _____

Signature: _____ Date: _____

Signature of Parent/Guardian: _____

*Relationship to patients if signed by anyone else (parent, legal guardian, personal representative, etc.)

Medical Information Release Form
(HIPPA Release Form)

Name:_____ Date of Birth:_____

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information to be release to:

☐Spouse: _____

☐Children: _____

☐Other:

☐Information to **not** be released to anyone.

**The release of information will remain in effect until terminated by me in writing.*

☐*I agree to receiving text messages regarding my dental appointments, any scheduling or rescheduling, and or anything related to my dental health.*

Signature: _____

Date: _____