WOODSTOCK SMILES
FAMILY & COSMETIC DENTISTRY

Patient Information: Legal Name: _____ Preferred Name: _____

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

Phone: (_____)_____ Work Phone: (_____)_____ Cell Phone: (_____)_____

Date of Birth: _____ Social Security Number: _____ ☐ Male ☐ Female

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Best method of contact: ☐ Home Phone ☐ Cell Phone ☐ Text messaging ☐ Email ☐ Postcard

Email Address: _____ How did you hear about us? _____

Responsible Party: Relationship to patients: ☐ Self **(If self skip to insurance information)** ☐ Spouse ☐ Parent ☐ Other

Name: _____ Relationship to Patient: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: (_____)_____

Employer: _____ Work Phone: (_____)_____ SSN#: _____

Insurance Information: Name of Insured: _____ DOB: _____ SSN#: _____

Employer: _____ Work Phone: (_____)_____ Insurance Company: _____

Group #: _____ ID #: (_____)_____

Ins Co Address: _____ Ins Co Phone: _____

MEDICAL HISTORY:

1. Are you allergic to latex or any medications? _____
2. Have you had serious illness, operation, or hospitalization in the past? _____
3. Has there been a change in your health in the last 2 years? _____
4. Are you a "bleeder" or have you had excessive bleeding following dental treatment? _____
5. Are you presently under the care of a physician? _____
6. Do you smoke or use tobacco products? _____
7. Do you take antibiotics before dental treatment? _____
8. Please list current medications? _____
9. **Have you had any of the following: Please Circle**

High Blood Pressure	**Kidney Disease**	**Chemical Dependency**	**Pacemaker**
Heart Bypass	**Joint Implants**	**Angina Heart Attack**	**Cancer**
Thyroid Disorders	**Tuberculosis**	**Stroke**	**Diabetes**
Emphysema	**AIDS/HIV**	**Asthma**	
Dialysis	**Breastfeeding**	**Radiation/Chemo**	
Heart Murmurs	**Prolapsed Mitral Valve**	**Hepatitis/Liver Disease**	

Currently Pregnant #of weeks _____ **Currently breast feeding** _____ **Other:** _____

PATIENT SIGNATURE _____ Date: _____ **Please read and sign back.**

General Office Policies and Explanations

Welcome to Woodstock Smiles! We are a dental office performing evaluation and treatment of oral health problems. With your consent we will perform procedures ranging from normal hygienic cleanings to restoration or replacement of missing teeth.

General Consent for treatment

1. Radiographs or (x-rays) of your teeth and tissue will be used to discern presence of conditions in your bony or calcified tissue. Normal frequency is bite-wing radiographs once per year, panoramic radiographs once per five years and other radiographs will be taken on a as needed basis.
2. Local Anesthetics may be necessary for your comfort during your dental treatment. On rare occasions bruising of involved tissue may occur. Prescribed, over the counter medications, herbs and supplements may have an adverse interaction with anesthetics.
3. Unanticipated dental needs may occur during treatment. They can include but are not limited to root canals, crown lengthening, or crown placement. Temporary or long-term discomfort or sensitivity can occur and in rare cases prescribed treatment may not have the intended effect.
4. Pictures of your teeth and mouth may be used to communicate with laboratories, treatment specialist or to describe necessary treatment.

Business Transaction

1. Forms of payment include cash, check, Visa, Master Card, American Express and Discover. We offer a 5% discount for cash/check paid in full at first appointment. Returned checks are subject to a $25 charge.
2. Your dental insurance is an agreement between you, your employer and the insurance company. It is your responsibility to know insurance benefits prior to treatment. Any remaining fees associated with your account are your responsibility. Should your insurance company send payment to you, the account balance will be expected directly from you/responsible party.
3. Adjunctive materials such as toothbrushes, mouth rinses, fluoride toothpaste and periodontal antibiotics are usually not covered under most insurance plans and are the patients responsibility.
4. Elective Cosmetic procedures will be paid in full at time of treatment.

Health Information

1. Our office is Health Information Portability (HIPPA) compliant when handling your private health information. At times it is required that we electronically transmit health information. We will make every effort to monitor and protect the distribution of any health related information. We will not share health information without your consent.

I understand and agree with each of the above items and have had the opportunity to ask questions and get further clarification related to each of these areas.

Adult signature required _____ **Date:** _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Guardian ☐ Power of Attorney