Witty Family & Cosmetic Dentistry

Name (first, middle initial, last) _____ Date_____

Address_____ City_____ Zip_____

Sex □ M □ F Age_____ Birthdate_____ Single____Married____Widowed_____

Social Security #_____ Email address:_____

Patient employer/school_____ Phone_____

Please provide insurance subscribers information:

Parent/Spouse's Name_____ Birthdate_____

Parent/Spouse Employer_____ SS#_____

Who can we thank for your business? Google Website Our sign Patient _____

Phone Numbers

Home (_____) _____ Work (_____) _____ Cell (_____)_____

IN CASE OF EMERGENCY CONTACT

Name _____ Phone _____

Dental History

Reason for today's visit _____

Please circle to indicate if you have had any of the following

Bad Breath	*Bleeding Gums*	*Blisters on lips or mouth*
Burning tongue	*Chew on one side of mouth*	*Cigarette, pipe or cigar smoking*
Dry mouth	*Clicking/popping jaw*	*Food collection btw teeth*
Grinding teeth	*Gums Swollen/tender*	*Lip/cheek biting*
Jaw Pain	*Loose teeth*	*Broken Fillings*
Pain in ear	*Mouth breathing*	*Sores/growths in mouth*

***Sensitivity to**: Cold Heat Sweets Biting*

None of the Above

How often do you brush? _____ Floss? _____

Name:_____

Medical History

Physician's name _____ Phone (____) _____

Medications

_____

_____

_____

_____

Allergies

□ *Aspirin* □ *Barbiturates (sleeping pills)* □ *Codeine* □ *Iodine*

□ *Latex* □ *Local Anesthetic* □ *Penicillin* □*Sulfa* □ *Other*_____

Health History

Please circle if you have had or have any of the following:

AIDS/HIV	Arthritis, Rheumatism	Artificial Heart Valve
Artificial Joints	Asthma	Autism
Back Problems	Bleeding Abnormally with Extractions	Blood Disease
Cancer	Chemical Dependency	Chemotherapy
Circulatory Problems	Congenital Heart Lesions	Cortisone Treatments
Cough, persistent or bloody	Diabetes	Emphysema
Epilepsy	Fainting or dizziness	Glaucoma
Headaches	Heart Murmur	Heart Problems
Hepatitis Type___	Herpes	High Blood Pressure
Jaundice	Jaw pain	Kidney Disease
Liver Disease	Low Blood Pressure	Mitral Valve Prolapse
Nervous Problems	Pacemaker	Psychiatric Care
Radiation Treatment	Respiratory Disease	Rheumatic Fever
Scarlet Fever	Shortness of breath	Sinus trouble
Skin Rash	Stroke	Swollen neck glands
Thyroid problems	Tonsillitis	Tuberculosis
Tumor or growth on head or neck	Ulcer	Weight loss, unexplained
Vision/Hearing impaired	**Blood Thinner**	**Bone Medicine**
None of the above		

*Do you require any special accomodations?*_____

Women:

Are you pregnant? _____ *if so due date* _____

*Nursing?*_____ *Taking Birth Control Pills?*_____

Witty Family and Cosmetic Dentistry

This letter is to inform you of our office policy regarding appointments. We do ask our patients to give us a 24 hours notice if you will not be able to keep a scheduled appointment. We do realize that emergencies happen and you may not be able to give as much notice, but please give us as much notice as possible.

- If you have 2 no call/no show missed appointments in a 2 month period of time, you will be discharged from our practice and asked to find another dentist.

- Patients that arrive 15 or more minutes late for an appointment will be asked to reschedule their appointment. Please be on time for your appointment to avoid this from happening to you.

By signing below I have read and understand the policy regarding missed and arriving late for appointments.

Initial _____

I ACKNOWLEDGE MY RIGHTS AS A PATIENT OF WITTY FAMILY AND COSMETIC DENTISTRY AND A COPY OF THE HIPAA(PRIVACY) POLICY WILL BE MADE AVAILABLE TO ME UPON REQUEST.

Initial _____

I give my permission for Witty Family and Cosmetic Dentistry to release necessary records to referring offices as they see fit.

Initial _____

By signing below I have read and understand the above statements and agree.

_____ _____

Signature Patient Name

_____

Date

Witty Family and Cosmetic Dentistry

Our Policy of Care and Payment

Ensuring that our patients receive high quality care is the goal of our practice.

Payment is due at time of treatment by cash, check and major credit cards.
We also offer Care Credit and Citi Health that allow you to spread your payments over time.

Insurance is designed to cover some, but not all, of your dental services. They are a method of reimbursement, not a substitute for payment. Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the carrier and the dentist. The patient is still the responsible party regarding dental fees and should have a full understanding about their benefit plan. We will be happy to submit your services to your insurance company, as long as you have provided us the appropriate insurance information prior to services being rendered.

DIVORCED PARENTS: We do not second party bill. The parent bringing the child to our facility will be responsible for required co-payments, deductibles etc. at the time of service.

Please Note: If you are receiving a composite (white) filling, your insurance company may not pay the full benefit price as they would for a amalgam (silver) filling. The difference in this price is the responsibility of the patient.

Insurance benefits are not meant to be a "pay all". Please know that in most cases there will be a co-payment/patient portion due at the time of each service.

I acknowledge that payment is due at the time of treatment. I agree that parents, guardians or personal representatives are responsible for all fees and services rendered for treatment of a minor/child. I accept full financial responsibility for all charges for services or items provided to me, to my minor/child, or to the patient for whom I have legal responsibility. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all charges.

_____ _____

Signature of Patient, Parent, or Personal Representative Date

_____

Relationship to Patient