WOOD FAMILY DENTAL

ABOUT YOU

Patient Name: _____ Patient Birth Date: / /

SSN#: _____ ☐ Male ☐ Female DL #: _____

Home Address: _____

City: _____ Zip: _____

Home Phone #: _____ Work Phone #: _____ Ext: _____

Cell Phone #: _____ Email Address: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Minor

How Did you hear about us? _____

_____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above

Name: _____ Birth Date: / / Relation: _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work: _____ SSN#: _____

Employer: _____ How Long There? _____ Occupation: _____

PRIMARY INSURED:		**SECONDARY INSURED:**	
Subscriber Name		Subscriber Name	
Subscriber SSN#		Subscriber SSN#	
Date of Birth		Date of Birth	
Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other	Relationship to Subscriber	☐ Self ☐ Spouse ☐ Child ☐ Other
Employer Name		Employer Name	
Employer Phone		Employer Phone	
Insurance Company		Insurance Company	
Insurance Group #		Insurance Group #	
Insurance Phone #		Insurance Phone #	

*****Please present card to receptionist to be photocopied*****

EMERGENCY

In the event of an emergency, who lives near you that we can contact?

Name: _____ Relationship: _____

Work Phone #: _____ Home Phone #: _____ Cell Phone #: _____

DENTAL HISTORY

How can we help you today? _____

Are you in pain? ☐ Yes ☐ No

If so, for how long? _____

Name/Location of previous dentist: _____

Do you like the color of your teeth? ☐ Yes ☐ No

Place a "yes" or "no" to indicate if you have had any of the following?

Bad breath	☐ Yes	☐ No	Please use the space below to elaborate on any answers: _____
Bleeding gums	☐ Yes	☐ No	
Blisters on the lips or mouth	☐ Yes	☐ No	
Burning sensation on the tongue	☐ Yes	☐ No	
Chew on one side of the mouth	☐ Yes	☐ No	
Cigarette, pipe, cigar smoking, vaping, chewing tobacco	☐ Yes	☐ No	
Clicking or popping jaw	☐ Yes	☐ No	
Dry mouth	☐ Yes	☐ No	
Fingernail biting	☐ Yes	☐ No	
Food collecting between teeth	☐ Yes	☐ No	
Grinding teeth	☐ Yes	☐ No	
Gums swollen or tender	☐ Yes	☐ No	
Jaw Pain or tiredness	☐ Yes	☐ No	
Loose teeth or broken fillings	☐ Yes	☐ No	
Mouth Breathing	☐ Yes	☐ No	
Pain when brushing teeth	☐ Yes	☐ No	
Prior orthodontic treatment (braces)	☐ Yes	☐ No	
Pain around ear	☐ Yes	☐ No	
Periodontal treatment (Deep Cleaning)	☐ Yes	☐ No	
Sensitivity to cold, heat, sweets	☐ Yes	☐ No	
Abnormal bleeding after extractions or surgery	☐ Yes	☐ No	
How often do you brush?			
How often do you floss?			

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions:

Are you currently seeing a physician, or been recently hospitalized?	☐ Yes	☐ No	Please use the space below to elaborate on any "yes" answers: _____
Do you take, or have you taken, Phen-Fen or Redux?	☐ Yes	☐ No	_____
Have you ever taken Fosamax, Boniva, Actonel, or any other medications containing bisphosphonates?	☐ Yes	☐ No	_____
Are you on a special diet?	☐ Yes	☐ No	_____
Do you use tobacco?	☐ Yes	☐ No	_____
Do you use controlled substances?	☐ Yes	☐ No	_____
Women are you:			_____
Pregnant/Trying to get pregnant?	☐ Yes	☐ No	_____
Taking oral contraceptives?	☐ Yes	☐ No	_____
Nursing?	☐ Yes	☐ No	_____

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics
☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs
☐ None ☐ Other *If yes, please explain:* _____

Please list all medications you are currently taking: ☐ None

WOOD FAMILY DENTAL

Do you have, or have you had any of the following?

AIDS/HIV POSITIVE	☐ Yes	☐ No	Hepatitis A, B, C (Please Circle)	☐ Yes	☐ No
Alzheimer's Disease	☐ Yes	☐ No	Herpes	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	**High Blood Pressure**	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	High Cholesterol	☐ Yes	☐ No
Angina	☐ Yes	☐ No	Hives or Rashes	☐ Yes	☐ No
Arthritis/Gout	☐ Yes	☐ No	Hypoglycemia	☐ Yes	☐ No
Artificial Heart Valve; Date:	☐ Yes	☐ No	Irregular Heartbeat	☐ Yes	☐ No
Artificial Joint; Date:	☐ Yes	☐ No	**Infective Endocarditis**	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Kidney Problems	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No
Breathing Problem	☐ Yes	☐ No	Lung Disease	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	**Mitral Valve Prolapse**	☐ Yes	☐ No
Chemotherapy	☐ Yes	☐ No	Osteoporosis	☐ Yes	☐ No
Chest Pains	☐ Yes	☐ No	Pain in Jaw Joints	☐ Yes	☐ No
Crohn's Disease	☐ Yes	☐ No	Parathyroid Disease	☐ Yes	☐ No
Cold Sores/Fever Blisters	☐ Yes	☐ No	Psychiatric Care	☐ Yes	☐ No
Convulsions	☐ Yes	☐ No	Radiation Treatments	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Recent Weight Loss	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Drug Addiction	☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No
Easily Winded	☐ Yes	☐ No	Rheumatism	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Scarlet Fever	☐ Yes	☐ No
Epilepsy or Seizures	☐ Yes	☐ No	Shingles	☐ Yes	☐ No
Excessive Bleeding	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Excessive Thirst	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Fainting Spells/Dizziness	☐ Yes	☐ No	Spina Bifida	☐ Yes	☐ No
Frequent Cough	☐ Yes	☐ No	Stomach/Intestinal Disease	☐ Yes	☐ No
Frequent Diarrhea	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Frequent Headaches	☐ Yes	☐ No	Swelling of Limbs	☐ Yes	☐ No
Genital Herpes	☐ Yes	☐ No	Thyroid Disease	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Tonsillitis	☐ Yes	☐ No
Hay Fever	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart Attack/Failure; Date:	☐ Yes	☐ No	Tumors or Growths	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No
Heart Pacemaker; Date:	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Heart Trouble/Disease	☐ Yes	☐ No	Yellow Jaundice	☐ Yes	☐ No
Hemophilia	☐ Yes	☐ No	Any serious illness not listed above?	☐ Yes	☐ No

IMPORTANT: I UNDERSTAND THE INFORMATION I HAVE GIVEN TODAY IS CORRECT TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT THIS INFORMATION WILL BE HELD IN THE STRONGEST CONFIDENCE AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY PERSONAL INFORMATION, MEDICAL STATUS OR INSURANCE. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT. A FEE OF 1.5% WILL BE CHARGED TO MY ACCOUNTS 60 DAYS PAST DUE, IN THE EVENT OF COLLECTION ACTION, I AGREE TO PAY A THIRD OF THE OUTSTANDING BALANCE AS ATTORNEY'S FEES.

I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATINO RENDERED TO MY CHILD OR ME DURING THE PERIOD OF SUCH DENTAL CARE TO THIRD PARTY PAYORS AND/OR HEALTHCARE PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DENTIST THE BENEFITS OTHERWISE PAYABLE TO ME. I UNDERSTAND THAT MY INSURACE CARRIER MAY PAY LESS THAN THE ACTUAL BILL FOR RENDERED SERVICES. I AGREE TO BE RESPONSIBLE FOR PAYMENT OF ALL SERVICES RENDERED ON MY BEHALF OR MY DEPENDENTS BEHALF.

Signature: _____ **Date:** _____

Financial and Insurance Policies

Welcome to our Family! Thank you for choosing our office as your dental healthcare provider. Our commitment is to provide you with the best possible dental care so that you may attain optimum oral health.

In order to realize these goals, we require you to read and understand our financial and payment policy.

_____**(Initial Here) Please Note:** Payment is due at the time that service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover, American Express, Apple Pay, and CareCredit.

If you have dental insurance, please understand the following:

- Your insurance is a contract between you and/or your employer, and the insurance company. We are not party to your contract.

- Not all services necessary for your care are covered benefits. This depends on your insurance policy. All policies are different. These are arbitrary decisions made by insurance companies and we have no way of knowing all of the clauses, limitations, and restrictions put in place by your policy

- It is our goal to assist you in understanding and optimizing your insurance benefits. We attempt to estimate your deductibles, co-payments, covered charges, maximums, and other matters related to determining your benefits. **However, it is your carrier that determines your benefits and it is your responsibility to verify these coverages.**

Please understand that as your dentalcare provider, our relationship and priority is with you, the patient. Dr. Wood does not treatment plan based on your insurance coverage or allow insurance companies to dictate the type of care that you receive.

As a courtesy to you, we will file and process all of your dental insurance claims and accept assignment of benefits. We will provide you with an insurance estimate; however, it is not a guarantee that insurance will pay exactly as estimated.

All charges you incur are your responsibility, regardless of your insurance coverage. We ask that you pay the deductible, co-payment, and/or co-insurance at the time we provide service to you.

Insurance payments are ordinarily received within 30-60 days after filing your claim. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company. If payment is not received or your claim is denied, you will be responsible for paying the full amount at that time.

Delinquency: All accounts must be paid in full within thirty (30) days of completion of each specific treatment (less anticipated insurance payments). Any accounts not paid within the thirty days will be considered delinquent. If your account is turned over to a collection agency, the collection fees will be added

to your portion due. You agree to pay all costs incurred, including lawyer's fees and court costs. In case of suit, you agree the venue shall be in Lake County, IL

Missed Appointment(s) and Cancellation(s): Our goal is to provide your treatment in a timely manner with as few visits as necessary. In order to provide the best services to our patients, we require advanced notice if you are going to miss an appointment. **Your appointment time has been reserved specifically for you.** A missed appointment is defined as:

- Failure to show up for a previously scheduled appointment (or)
- Failure to give at least 48 hours notice to change/cancel a previously scheduled appointment

After the first offence, any patient that fails to keep their scheduled appointment or give a 48-hour cancellation notice will be charged a **missed appointment fee of $35**. This fee must be paid before a new appointment is scheduled. We may also request that a patient provide us with a credit card to reserve an upcoming appointment.

Minors: The parent(s) or guardian(s) must accompany a minor for their first visit to our office. The parent or guardian who has consented to treatment is responsible for full payment at time of service.

Returned Check: There is a $29 fee for any checks returned unpaid by the bank.

Consent: I have read, understand, and agree to the above terms and conditions. I authorize my insurance company to pay my dental benefits directly to Wood Family Dental. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered.

Communications with you: By signing below, you are authorizing us to call you at any number you provide including calls to mobile devices for any lawful purpose. We or our agents may call by telephone regarding your account. You agree that we may place such calls using automatic dialing/announcing device. You agree that we may make such calls to a mobile telephone. You agree that we may, for training purposes or to evaluate the quality of our service, listen to and record phone conversations you have with us.

Patients Name (Please Print): _____

Responsible Party (Please Print): _____

Signature: _____ **Date:** _____

Wood Family Dental
Brandon Wood DMD, PC

You may refuse to sign this acknowledgement

I have received a copy of this office's "Notice of Privacy Practices".

A hardcopy is available at the front desk and a copy will be provided to you if requested.

Print Name: _____

Signature: _____

Date: _____

*****Office Use Only*****

We attempted to obtain written acknowledgement of receipt of our "Notice of Privacy Practices", but acknowledgement could not be obtained because:

- Individual refused
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)