MEDICAL HISTORY UPDATE

Patient Name: ____ Patient Birth Date: / /

Home Address: ____

City: ______________________________________ Zip: ____________________________________

Cell Phone #: __________________________ Email Address: _______________________________

Home Phone #: ________________________ Work Phone #: ______________________ Ext: _______

Have you had a change of insurance? ☐ **Yes** ☐ **No**

Are you currently seeing a physician, or have you been recently hospitalized?	Yes	No
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
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

Please use the space below to elaborate on any "yes" answers: ______________

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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: ☐ None

Wood Family Dental

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

Condition	Yes	No	Condition	Yes	No
AIDS/HIV POSITIVE	Yes	No	Hepatitis (Type____)	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

Signature: ______________________________ **Date:** ____________________

WOOD FAMILY DENTAL

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

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)

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