PATIENT INFORMATION (CONFIDENTIAL)

LEGAL FIRST NAME_____ MI____ LEGAL LAST NAME_____

BIRTHDATE_____/_____/_____ SS#_____-_____-_____ SEX_____

P.O. BOX_____ CITY_____ STATE_____ ZIP_____

PHYSICAL ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE (_____)_____-_____ CELL PHONE(_____)_____-_____

EMAIL ADDRESS_____

CAN WE CONTACT YOU BY TEXT MESSAGE OR EMAIL FOR APPOINTMENT AND RECALL REMINDERS? ☐ YES ☐ NO

CHECK APPROPRIATE: ☐ MINOR ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED ☐ SEPARATED

STUDENT: ☐ YES ☐ NO ☐ FULL TIME ☐ PART TIME
NAME OF SCHOOL_____ CITY_____ STATE_____

PATIENT'S EMPLOYMENT: ☐ RETIRED ☐ UNEMPLOYED ☐ EMPLOYED EMPLOYER _____
CITY _____ STATE ____ ZIP_____ WORK PHONE (_____)_____-_____

IF MARRIED, NAME OF SPOUSE _____EMPLOYER _____
CELL PHONE (_____)_____-_____ WORK PHONE (_____)_____-_____

IF MINOR, NAME OF PARENT(S) OR GUARDIAN CHILD LIVES WITH: ☐ FATHER ☐ MOTHER ☐ BOTH PARENTS ☐ GUARDIAN ☐ OTHER
MOTHER'S NAME _____PHONE (_____)_____-_____
FATHER'S NAME _____PHONE (_____)_____-_____

PERSON TO CONTACT IN CASE OF EMERGENCY _____
PHONE (_____)_____-_____ RELATIONSHIP TO PATIENT _____

HOW DID YOU HEAR ABOUT US? _____

RESPONSIBLE PARTY INFORMATION

SELF ☐

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____
BIRTHDATE _____/_____/_____ SS#_____-_____-_____
DRIVER'S LICENSE #_____ST_____
MAILING ADDRESS_____ PHONE(_____)_____-_____
EMPLOYER_____ WORK PHONE(_____)_____-_____
IS THIS PERSON CURRENTLY A PATIENT IN OUR OFFICE? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

PLEASE GIVE CARD TO RECEPTIONIST

PRIMARY DENTAL INSURANCE
LEGAL NAME OF INSURED _____SS#____-____-____ BIRTHDATE_____/_____/_____
EMPLOYER _____ADDRESS _____PHONE(_____)_____-_____
INSURANCE COMPANY _____ PHONE(_____)_____-_____
POLICY ID# _____GROUP # _____

CARD ON FILE ☐
NO DENTAL INSURANCE ☐

DO YOU HAVE ADDITIONAL COVERAGE? YES ☐ NO ☐

DATE _____/_____/_____

(Rev.12/2020)

Medical History

Patient's name_____ Birthdate_____/_____/_____

Are you allergic to or have you had a reaction to any of the following: Check all that apply

- ☐ Amoxicillin
- ☐ Ampicillin
- ☐ Aspirin
- ☐ Augmentin
- ☐ Benadryl
- ☐ Cephalexin
- ☐ Cephalosporin
- ☐ Cipro
- ☐ Cleocin
- ☐ Clindamycin
- ☐ Codeine
- ☐ Demerol
- ☐ Epinephrine
- ☐ Erythromycin
- ☐ Ibuprofen/Motrin
- ☐ Keflex
- ☐ Latex/Rubber
- ☐ Lortab/Norco
- ☐ Metals (Nickel, Mercury, etc.)
- ☐ Morphine
- ☐ Novocain/Anesthetics
- ☐ Penicillin
- ☐ Percocet/Vicodin
- ☐ Steroids
- ☐ Sulfa Drugs
- ☐ Tylenol
- ☐ Valium/Triazolam
- ☐ Zithromax

Other_____

_____

☐ **None**

Do you or have you had any of the following: Check all the apply

Heart Issues

- ☐ AFIB
- ☐ Angina
- ☐ CAD
- ☐ Heart Attack
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Alcohol/Drug Dependency
- ☐ Allergies
- ☐ Anemic
- ☐ Anxiety
- ☐ Arthritis/Rheumatism
- ☐ Artificial Joint(s)/Valve
- ☐ Asthma
- ☐ Autism
- ☐ Cancer/Leukemia
- ☐ Chicken Pox/ Shingles
- ☐ Chronic Cough
- ☐ Cold Sores/Blisters
- ☐ COVID-19
- ☐ Diabetes Type1 or 2
- ☐ Eating Disorder
- ☐ Epilepsy/Seizures
- ☐ Fainting/Dizzy Spells
- ☐ Fibromyalgia
- ☐ Gastric Bypass
- ☐ Hand, Foot, & Mouth
- ☐ A ☐ B ☐ C Hepatitis
- ☐ High/Low Blood Pressure
- ☐ HIV/AIDS
- ☐ HPV
- ☐ Hypoglycemia
- ☐ Kidney Trouble
- ☐ Liver Disease
- ☐ Lung/Breathing Problems (COPD, Emphysema, Shortness of Breath)
- ☐ MRSA
- ☐ Meningitis
- ☐ Mental Health Care
- ☐ Mono
- ☐ MS
- ☐ Nervousness
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ Stroke/TIA
- ☐ Swelling (Hands, Feet, Ankles)
- ☐ Thyroid Problems
- ☐ Transplant
- ☐ Tuberculosis (TB)
- ☐ Ulcers

Other_____

_____

☐ **None**

Are you currently taking of using any of the following: Check all the apply

- ☐ Antibiotic
- ☐ Anti-Depressants
- ☐ Aspirin (Recently or Everyday)
- ☐ Beta Blocker
- ☐ Birth Control
- ☐ Blood Thinners (Currently or Past) (Coumadin, Eliquis, Plavix, Warfarin, Xarelto, Other)
- ☐ Diabetes Medication
- ☐ Asthma Medication/Inhaler
- ☐ Herbal Supplement
- ☐ High/Low Blood Pressure Medication
- ☐ Acid Reflux Medication (Nexium, Omeprazole, Prevacid, Other)
- ☐ Osteoporosis Medication (Actamel, Boniva, Fosamax, Reclast, Other)
- ☐ Psychiatric Medication
- ☐ RA (Remicade, Humira, Other)
- ☐ Statin Medication
- ☐ Steroids
- ☐ Tobacco/Marijuana

Other_____

_____

_____

_____

_____

_____

☐ **See attached list**

☐ **None**

I certify that I have read and understand this health questionnaire. The questions have been answered accurately to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

_____

Signature of patient, legal guardian or authorized agent of the patient Date _____/_____/_____

_____

Witness

(Rev- 12/2020)

Medical History Continued

Patient's name _____Birthdate _____/_____/_____

- Reason for your visit today _____
- When was your last dental visit? _____/_____/_____ Do you regularly visit your dentist twice a year? ☐YES ☐NO
- Previous dentist name _____Address _____ Phone # (_____)_____-_____
- How often do you brush your teeth? _____ How often do you floss your teeth? _____
- Are you in good health? ☐YES ☐NO Date of your last physical exam _____/_____/_____
- Physician's name _____Address _____ Phone # (_____)_____-_____
- ☐YES ☐NO Are you under the care of a physician now?
- ☐YES ☐NO Have there been any changes in your health within the past year?
- ☐YES ☐NO Hospitalized or Surgery
  If yes, please explain _____
- ☐YES ☐NO Do you bruise easily?
- ☐YES ☐NO Have you ever had a blood transfusion?
- ☐YES ☐NO Do you or have you used controlled substances?
- ☐YES ☐NO Do you have any disease, condition or problem not listed that you think we should know about?
  If yes, please explain _____
- ☐YES ☐NO Do your gums bleed when brushing or flossing?
- ☐YES ☐NO Do you feel any pain in your teeth?
- ☐YES ☐NO Are your teeth sensitive to HOT COLD SWEET SOUR?
- ☐YES ☐NO Do you have any sores or lumps in or near your mouth?
- ☐YES ☐NO Do you bite your lips or cheeks frequently?
- ☐YES ☐NO Does food get caught between your teeth?
- ☐YES ☐NO Do you clench or grind your teeth?
- ☐YES ☐NO Do you have frequent headaches?
- ☐YES ☐NO Have you had any head, neck, or jaw injuries?
- ☐YES ☐NO Have you noticed any loosening of your teeth?
- ☐YES ☐NO Have you had any abnormal/prolonged bleeding or difficult extractions in the past?
- ☐YES ☐NO Have you ever had any problems with your jaw such as pain, clicking, difficulty chewing or opening and closing?
- ☐YES ☐NO Have you ever received oral hygiene instructions?
- ☐YES ☐NO Have you ever had Periodontal (gum) treatment?
- ☐YES ☐NO Have you ever had a difficult time getting numb?
- ☐YES ☐NO Have you ever worn a biteplate, ortho appliance, partials, or dentures?
  If yes, date of placement _____/_____/_____
- ☐YES ☐NO Do you get heartburn or acid reflux on a regular basis?
- ☐YES ☐NO Have you ever taken Fen-Phen or Redux?
- ☐YES ☐NO Have you ever taken any drug to prevent osteoporosis such as Fosamax, Actamel, Boniva, or Reclast?
- If you could change ANYTHING about your smile, what would you change? _____

Women Only:

- ☐YES ☐NO Are you taking birth control pills?
- ☐YES ☐NO Are you pregnant or think you may be pregnant? If yes, what is your due date? _____/_____/_____
- ☐YES ☐NO Are you currently nursing?

Although we primarily treat the mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you may be taking, could have an important interrelationship with the dentistry that you will be receiving.

_____
Signature of patient, legal guardian or authorized agent of the patient Date _____/_____/_____

_____
Witness

Office Financial Policies and Federal Truth-In-Lending Statement

As a condition of your treatment by this office, financial arrangements must be made in advance. This practice depends upon reimbursement from our patients for the costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are rendered.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18%per annum) on the unpaid balance will be assessed on all accounts exceeding sixty (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient exam. Accounts that are over 90 days are considered past due and will be subject to a monthly rebilling fee of $10.00.

In consideration for the professional services to be rendered to me, (or, at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or licensed employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining account balance plus the sum of the collection fee (up to 40%) charged by the collection agency to whom a delinquent account is turned in for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary, I authorize the release of financially identifiable information concerning my account, including charges billed, payments made, and interest charges assessed, ect., to the dentist's collection agency or attorney should collection procedures become necessary. I also understand that if my account becomes delinquent that any discounts (ie: coupons, flyers, no insurance, or specials)given by the doctor will be removed and I will be responsible for the full value of said services provided.

I grant my permission to you or your assignee to contact me by telephone at any telephone number associated with your account, including wireless numbers, which could result in charges to you. We may also contact you by text messages or e-mails. I also agree to let this office leave messages concerning appointments and/or account information on my answering machine or with a family member.

I understand that appointments scheduled for myself, a minor child or ward that are not kept or canceled with 24 hours notice will be charged $35.00 for each appointment/hour scheduled.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, or facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted. I authorize assignment or payment of all dental benefits to which I or other family members are entitled, to be payable to Wendover Dental Care.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I acknowledge that I am aware of this office's Privacy Policies. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.
List names here: _____

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I agree to abide by the conditions outlined herein.

Signature of Patient, parent or guardian _____

Date _____/_____/_____ Relationship to patient_____

OVER PLEASE

HEALTH QUESTIONNAIRE ACKNOWLEDGEMENT

I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent dental appointment.

CONSENT TO PROCEED

I authorize Dr. McConnell and/or such associates or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic, and/or other pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effects, which may include, but are not limited to bruising; hematoma; cardiac stimulation; muscle soreness; and temporary or rarely, permanent numbness. I understand that occasionally needles break and may require surgical retrieval.Occasionally drops of local anesthetic may contact the eyes and facial tissues and cause temporary irritation.

I understand that as part of dental treatment, including preventive procedures such as cleanings and basic dentistry including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. Dental materials and medications may trigger allergic or sensitivity reactions.

After lengthy appointments, jaw muscles may also be sore or tender. Holding one's mouth open can, in a predisposed patient, precipitate a TMJ disorder. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, ect. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as blood thinners. I understand that taking the class of drugs prescribed for the prevention of osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume any and all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

Patient Name_____

_____
Signature of patient, legal guardian or authorized agent of the patient

Date _____/_____/_____

_____
Witness