WASSERMAN DENTAL
Patient Information Form

Date ___/___/____

Patient _____ **SS#** _____
Last Name First Name MI

Date of Birth ___/___/____ **Sex Assigned at Birth:** _____ **Gender Identity:** _____

Home Address _____
Street Apt# City State Zip

Phone # Home( )_____ Work( )_____ Cell( )_____

Email _____

Occupation _____ **Employer** _____

Employer Address _____
Street Suite# City State Zip

Emergency Contact _____ / _____ Phone # ( )_____
Name Relationship

Please list other members of your immediate family who are patients in our practice:

_____ _____ _____ _____

Whom may we thank for referring you?

☐ One of our valued patients (patient's name) _____

☐ Local Dental Society ☐ Our Website ☐ Other _____

Primary Dental Plan Name _____ Phone # _____

Address _____
Street City State Zip

Name of Insured _____ Date of Birth _____ SS# _____

Patient Relationship to Insured _____ Policy # _____ Group # _____

Secondary Dental Plan Name _____ Phone # _____

Address _____
Street City State Zip

Name of Insured _____ Date of Birth _____ SS# _____

Patient Relationship to Insured _____ Policy # _____ Group # _____

THIS FORM IS 2-SIDED. PLEASE TURN OVER TO COMPLETE.

Patient Responsibilities

We are committed to providing you with the best possible care to help you achieve your optimum oral health. Toward this goal, we would like to explain your financial and scheduling responsibilities.

Payment: Financial arrangements are discussed during the initial visit and a financial agreement is completed in advance of performing any treatment. We accept the following forms of payment: Visa, MasterCard, Discover, cash, and personal check.

Dental Benefit Plan: Your dental benefit plan is a contract between you or your employer and the dental benefit plan. Benefits and payments received are based on the terms of the contract negotiated between you or your employer and your plan. We are happy to help our patients understand and maximize their coverage. Our practice may or may not be a contracted provider with your dental benefit plan.

If we are a contracted provider with your dental benefit plan, you are responsible only for your portion of the approved fee as determined by your plan. We prefer to collect the patient's portion in full at time of service (deductible, co-insurance, co-pay, or any amount not covered by the dental benefit plan). If our estimate of your portion is less than the amount determined by your plan, the amount billed to you will be adjusted to reflect this.

If we are not a contracted provider with your dental benefit plan, you are responsible to pay for treatment rendered. Our practice will file a claim with your dental benefit plan, with the understanding you will obtain reimbursement directly from your plan.

Scheduling of Appointments: To maintain the utmost service and care, we require 48 business hour notice to reschedule an appointment. With less than 48 business hour notice, we may collect a fee of $75 per hour-long appointment. To serve our patients in a timely manner, we may need to reschedule an appointment if a patient is fifteen minutes late or more arriving to our practice. To reschedule an appointment due to late arrival, we may collect the same fee of $75 per hour-long appointment.

Unencrypted email is not a secure form of communication. There is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to, or intercepted by unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. Our first email to you will certify the email address you provide.

☐ I consent and accept the risk in receiving information via email. I understand I can withdraw my consent at any time.
☐ I consent only to receiving appointment reminders via email. I understand I can withdraw my consent at any time.
☐ I do not consent to receiving any information via email. I understand I can change my mind and provide consent later.

Authorizations

- The information I have provided is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services I may need and have consented to during diagnosis and treatment. _____ (initial)
- I have read the above form and agree to the financial and scheduling terms. _____ (initial)
- I authorize Wasserman Dental to contact me at the cell phone number I have provided. Content may include appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. Wasserman Dental may:

☐ Call.
☐ Text.
☐ Call and text.

_____ (initial)

- I authorize the release of information necessary to process my dental benefit claims. _____ (initial)
- If we are a contracted provider with your dental benefit plan: I hereby authorize payment directly to this doctor otherwise payable to me. _____ (initial)
- I have received a copy of the Wasserman Dental Notice of Privacy Practices. _____ (initial)
- I have received a copy of the Dental Materials Fact Sheet as required by law. _____ (initial)

Patient Signature: _____ **Date:** _____

M / D / Y

WASSERMAN DENTAL
Confidential Health History

Patient Name _____ **Date of Birth** ___/___/___

Chief Dental Complaint(s) _____

_____

Have you had problems with prior dental treatment? ☐ Yes ☐ No

If yes, please explain: _____

Please provide us with your last dentist's information below:

Dentist's Name	Phone #	Approximate Date of Last Visit / /	
Address	City	State	Zip

Please describe your general health: _____

What is your current height? _____ **What is your current weight?** _____

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

		Yes	No
1.	Injury to head, neck, jaw or teeth	☐	☐
2.	Recurrent head, face, jaw or neck pain	☐	☐
3.	Difficulty opening or closing jaw	☐	☐
4.	Sore throat, hoarseness or difficulty swallowing	☐	☐
5.	Dry mouth, recurrent oral sores or irritation	☐	☐
6.	Bleeding, infected gums or loose teeth	☐	☐
7.	Decayed or broken teeth	☐	☐
8.	Poor sleep, snoring or daytime sleepiness	☐	☐
9.	High blood pressure	☐	☐
10.	Angina, chest pain or heart attack	☐	☐
11.	Irregular or rapid heart beats	☐	☐
12.	Pacemaker or defibrillator	☐	☐
13.	Murmur, valvular disease or other heart defect	☐	☐
14.	Artificial heart valve	☐	☐
15.	Cardiac or vascular surgery	☐	☐
16.	Heart failure	☐	☐
17.	Stroke	☐	☐
18.	Emphysema or chronic bronchitis	☐	☐
19.	Asthma	☐	☐
20.	Lung infections (pneumonia, tuberculosis, other)	☐	☐
21.	Anemia	☐	☐
22.	Bleeding disorder or excessive clotting	☐	☐
23.	HIV infection or other immune deficiency	☐	☐
24.	Autoimmune disease (RA, lupus, other)	☐	☐
25.	Cancer	☐	☐
26.	Radiation or chemotherapy for cancer	☐	☐
27.	Organ transplant	☐	☐
28.	Diabetes	☐	☐
29.	Thyroid disease	☐	☐
30.	Adrenal or other endocrine disease	☐	☐
31.	Currently pregnant or breast feeding	☐	☐
32.	Reflux, peptic ulcer or colon disease	☐	☐
33.	Hepatitis or other liver disease	☐	☐

		Yes	No
34.	Renal dialysis or other kidney disease	☐	☐
35.	STD (syphilis, gonorrhea, HSV, HPV or other)	☐	☐
36.	Arthritis, persistent stiffness, painful joints	☐	☐
37.	Artificial joint, implant	☐	☐
38.	Treatment for Osteoporosis	☐	☐
39.	Seizures	☐	☐
40.	Numbness, tingling, or paralysis	☐	☐
41.	Muscle weakness or multiple sclerosis	☐	☐
42.	Movement disorders (Parkinson's, other)	☐	☐
43.	Cognitive impairment (Alzheimer's, other)	☐	☐
44.	Depression, anxiety disorder	☐	☐
45.	Psychiatric conditions (schizophrenia, other)	☐	☐
46.	Do you/ have you ever smoked/ used tobacco?	☐	☐
47.	Do you or have you ever abused alcohol?	☐	☐
48.	Do you or have you ever used illicit substances?	☐	☐
49.	Any other medical conditions not listed above	☐	☐
	Please specify		

Allergies		Yes	No
50.	Penicillin	☐	☐
51.	Sulfa drugs	☐	☐
52.	Dental anesthetics	☐	☐
53.	Metals (rings or earrings)	☐	☐
54.	Latex	☐	☐
55.	Other	☐	☐
	Please specify		

Has anyone in your immediate family ever had?

56.	Heart disease	☐	☐
57.	Diabetes	☐	☐
58.	Blood disorder	☐	☐
59.	Cancer	☐	☐
60.	Tuberculosis	☐	☐
61.	Mental/emotional disorders	☐	☐

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Please list all prescription and non-prescription drugs you are currently taking (including doses and reasons):

1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list any history of hospitalizations or emergency room visits (including dates and reasons):

1.	4.
2.	5.
3.	6.

If you currently have a physician, please provide us with the information below:

Physician's Name	Phone #	Approximate Date of Last Visit / /	
Address	City	State	Zip

The practice of dentistry involves treating the whole person. If the dentist determines the potential for medical compromise exists, medical consultation may be required prior to the commencement of dental treatment.
I authorize the dentist to contact my physician.

Patient Signature: _____ **Date:** _____
M / D / Y

I have read and understood the above questionnaire and answered all questions truthfully to the best of my ability. If ever my health or medications change, I will inform my dentist at my next appointment. Further, I will not hold my dentist, or any other member of his staff, responsible for any errors or omissions I may have made in the completion of this form.

Patient Signature: _____ **Date:** _____
M / D / Y

Medical Updates

I have reviewed my Health History and confirm that it accurately states past and present conditions.

DATE	PATIENT SIGNATURE	CHANGES TO HEALTH HISTORY	DENTIST INITIALS
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____