

**PATIENT REGISTRATION**

Patient's Name: \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_ Pager: \_\_\_\_\_

Patient's Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Patient's Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

If patient is over age 18 and a student, student status:  Full time  Part time Name of school and location: \_\_\_\_\_

I would like to receive appointment reminders via e-mail: yes or no Email: \_\_\_\_\_

**Responsible Party (if someone other than the patient is responsible for the bill)**

Responsible Party's Name: \_\_\_\_\_  
(First) (Middle Initial) (Last)

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_ Pager: \_\_\_\_\_

Responsible Party's Birth date: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Holder  Secondary Policy Holder

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to patient:  Self  Spouse  Parent  Other

Insured Social Security or Member Identification Number (if not SS #): \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to patient:  Self  Spouse  Parent  Other

Insured Social Security or Member Identification Number (if not SS #): \_\_\_\_\_ Insured DOB: \_\_\_\_\_

Employer: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Telephone: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

In case of emergency is there someone we may contact \_\_\_\_\_

Telephone # \_\_\_\_\_ Relationship to you \_\_\_\_\_

**After completing the front portion of this form, please review and sign our financial policy on the back.**

## 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 under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_
- 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
- Other If yes, please explain: \_\_\_\_\_

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

- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medicine <input type="radio"/> Yes <input type="radio"/> No        | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# Wolken

Providing Family and Cosmetic Dentistry with Personal Care

## Dental Health Questions

Correct answers to the following questions will allow your dentist to treat you on a more individual basis, providing the care appropriate for your particular needs. Circle, yes or no, whichever applies, in response to the following questions. Your answers are for our records only and will be considered confidential.

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

How did you hear about our practice? Friend or Family Member (name) \_\_\_\_\_

Insurance Directory Advertisement Other \_\_\_\_\_

- |   |     |    |
|---|-----|----|
| 1. Are you having any discomfort at this time?            | yes | no |
| 2. Date of your last dental visit _____                   |     |    |
| 3. Have you been treated for periodontal disease?         | yes | no |
| 4. Do you have or have you ever had any of the following? |     |    |
| Bleeding, sore gums.....                                  | yes | no |
| Unpleasant taste/bad breath.....                          | yes | no |
| Burning tongue/lips.....                                  | yes | no |
| Frequent blisters lips/mouth.....                         | yes | no |
| Swelling/lumps in mouth.....                              | yes | no |
| Ortho treatments (braces).....                            | yes | no |
| Biting cheeks/lips.....                                   | yes | no |
| Clicking/popping jaw.....                                 | yes | no |
| Difficulty opening or closing jaw.....                    | yes | no |
| Loose teeth.....  | yes | no |
| Sensitive to hot or cold.....                             | yes | no |
| Sensitive to sweets.....                                  | yes | no |
| Food impaction.....                                       | yes | no |
| Grinding/clenching.....                                   | yes | no |
| Shifting or change in bite.....                           | yes | no |

5. Do you use the following?
- |              |     |    |                  |
|--------------|-----|----|------------------|
| Toothbrush   | yes | no | How Often? _____ |
| Dental floss | yes | no | How Often? _____ |

**NOTICE OF PRIVACY PRACTICES  
PATIENT CONSENT FORM**

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my medical treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* from time to time and that I contact this organization at any time at the below address to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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**PERMISSION TO LEAVE A MESSAGE**

Due to HIPAA regulations, we are not permitted to leave a message regarding your appointments without prior permission from you. You need to give us verbal permission which only then we can document in your account. If you do not provide permission then you will receive a phone call requesting that you contact Dr. Wolken's office.

This permission will only be used to leave messages for appointments, no other message will be left nor any information given to anyone without written permission from you.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_



## WOLKEN DENTAL FINANCIAL POLICY

It is the patient's responsibility to provide our office with the correct billing and insurance information. This includes name, date of birth, social security number, place of employment, name of employee carrying insurance; as well as the name and address of the insurance company. Failure to provide the correct information may result in insurance denial and the patient assuming full responsibility for the balance.

We have several financial options available for your convenience to enable you to receive the proper dental care. We accept all major credit cards, debit cards, checks and cash. We offer the Care Credit Card as our extended payment option for those who qualify.

### **Insurance and Insurance Collection**

We participate in many dental plans and we will be happy to submit your insurance claims at no charge, however, we are not responsible for the decisions made by your insurance company regarding payment or non-payment on your claim. Dental insurance is a contract between the patient and the insurance carrier, not between the carrier and the dentist. Knowing your insurance plan benefits is your responsibility. You may contact your Human Resources/Personnel Department or insurance carrier to verify your dental benefits.

A request to your insurance company to pre-authorize dental treatment will be done before treatment is started. The pre-authorization will give an overview of the projected costs allowed by your particular insurance plan. Any treatment not pre-authorized by your insurance company will necessitate payment in full for treatment by the patient. Payment for unauthorized treatment must be paid when treatment is started. Any unpaid balance is due when treatment is completed.

The estimated portion not covered by your insurance is due at the time the treatment is performed. Please be aware that we are only capable of estimating your portion and we will collect at the time services are rendered. Once the insurance company has paid their portion of the charges, if there is a balance remaining, we will mail you a statement.

### **Patients under the age of 18**

The adult accompanying a minor and the parents (or guardian) of the minor are responsible for the full payment. For unaccompanied minors, non-emergency treatment will be denied unless the charges have been pre-authorized to an approved credit plan, credit card or payment by cash or check at the time of service.

### **Rebilling Fees**

We reserve the right to assess your account with a finance charge of 1.5% for any outstanding balance over 30 days old.

### **Broken or Missed Appointments**

We ask that patients make every effort not to change reserved dental appointments. If you find that you must change your appointment, **we require a minimum of 24 hour notice** so that we may accommodate another patient. A charge will be applied to broken and missed appointments without advanced notification.

**I have read the Financial Policy and I understand and agree to the terms. I acknowledge that payment is due at the time of treatment, unless other arrangements are made in advance. 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.**

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature of Patient or Responsible Party**

**X** \_\_\_\_\_ **Date** \_\_\_\_\_  
**Signature of Co-Responsible Party (when applicable)**