Wells Family Dental Group

L. Brett Wells DDS PA & L. Brett Wells DDS II, PLLC

Thank you for choosing Wells Family Dental Group. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name _____
Last First Middle Preferred Name

Address _____
Street

_____
City State Zip Code

Employer _____ Social Security_____

Birthdate _____ Email Address_____

Male ❒ Female❒

Phone:
Home (____)_____ Work (____)_____

Cell (____)_____

How would you prefer a courtesy reminder? ❒ Cell Phone ❒ Work ❒ Home ❒ Email ❒ Text

Emergency Contact

Name _____ Phone (____)_____

Relationship to Patient _____

Insurance Information

Subscriber Name _____ SS#_____ DOB_____

Employer_____ Insurance Company _____

Ins Co Phone #_____ Group#_____

Subscriber Relationship to Patient _____

Payment and Insurance Authorization

I hereby authorize Wells Family Dental Group to accept the Assignment of Benefits from my Primary Dental Insurance Carrier, otherwise payable to me. I can opt for payment to be released to me directly with the knowledge that the total cost of services rendered is due on the date of service. I understand that I am responsible for all costs associated with treatment at this office.

Patient Name _____ Date _____

Patient or Parent / Guardian Signature_____

New Patient Questions

How did you hear about our office?_____

What is your reason for todays visit?_____

What did you like most about your last dentist? _____

Past Medical History and Current Health Information

❒Abnormal Bleeding
❒Acid Reflux
❒Allergies - Seasonal
❒Anemia
❒Angina Pectoris
❒Arthritis
❒Artificial Heart Valve
❒Asthma
❒Blood Transfusion
❒Cancer: Type / Diagnosed
_____
❒Chemotherapy
❒Diabetes: Type _____
❒Difficulty Breathing
❒Drug Abuse
❒Emphysema
❒Epilepsy
❒Facial Surgery
❒Fainting Spells
❒Fever Blisters
❒Frequent Headaches
❒Glaucoma
❒Heart Surgery: Type / When
_____
❒HIV+ AIDS
❒HPV
❒Heart Attack – Date_____
❒Heart Murmur
❒Hemophilia
❒Hepatitis A
❒Hepatitis B
❒Hepatitis C
❒High Blood Pressure
❒High Cholesterol
❒Joint Replacement: What/When
_____
❒Kidney Problem
❒Liver Problems
❒Low Blood Pressure
❒Mitral Valve Prolapse
❒Pace Maker
❒Psychiatric Problems
❒Rheumatic Fever
❒Seizures
❒Sexually Transmitted Disease
❒Shingles
❒Sickle Cell Disease
❒Sinus Problems
❒Stroke
❒Thyroid Problems
❒Tuberculosis
❒TMJ
❒Osteoporosis

Do You have any known Allergies?
❒ Yes ❒ No

If Yes, Please specify:
❒Aspirin
❒Codeine
❒Dental Anesthetics
❒Erythromycin
❒Latex
❒Metals
❒Penicillin
❒Sulfa
❒Tetracycline
❒Other Allergies:
_____

Do You Smoke or Use Tobacco?
❒ Yes ❒ No
If Yes, how often and what type?
_____

Female Patients Only
Birth Control Pills❒Yes ❒No
Pregnant ❒Yes ❒No
Due Date_____
Are you Nursing? ❒Yes ❒No

Other History we should be aware of?
_____

Please List any Medications you are currently taking:
_____

Are you currently taking Fosamax, Actonel or Boniva? ❒ Yes ❒ No If yes, for how many years? _____

Do you require Pre-Medication (antiboitics prescribed by your primary care physician) prior to dental treatment? ❒ Yes ❒ No

Authorization for Treatment
I hereby authorize Wells Family Dental Group to perform diagnostic and therapeutic procedures as may be necessary for proper dental care. I hereby authorize Wells Family Dental Group to administer medications as may be necessary for dental care. I authorize and give consent to perform dental services agreed between doctor/patient or parent guardian to be necessary and advisable including the use of local anesthesia and other medication as indicated.
I certify the above statements regarding my medical history / condition(s) are correct to the best of my knowledge.

Patient Name _____ Date _____

Patient or Parent / Guardian Signature_____

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Acknowledgement of Receipt of Notice of Privacy Practices

Name _____
Last First Middle

Address _____
Street

_____
City State Zip Code

I have received a copy of the Notice of Privacy Practices for the above named practice.

Patient Name _____ Date _____

Patient or Parent / Guardian Signature_____

For Office Use Only

We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:

- ❒ An emergency existed & a signature was not possible at the time.
- ❒ The individual refused to sign.
- ❒ A copy was mailed with a request for a signature by return mail.
- ❒ Unable to communicate with the patient for the following reason:

  _____

- ❒ Other: _____

Prepared By _____

Signature _____

Date _____

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Authorization for Release of Information – Compound Release

Name of Patient _____ Date of Birth_____
This form is how Wells Family Dental Group can communicate with you and authorizes us to release protected health information.

Check each entity you approve	Check type of information that can be provided
❒Voice Mail	❒Results of lab tests/x-rays ❒Other _____
❒Other person (s) (Provide name and phone number)	❒Financial ❒Medical
❒Email communication – Provide email address _____ *For email communication to occur, accept the disclosure below:	❒Financial ❒Medical ❒Appointment reminders ❒Breach notification
❒Text communication – Provide number* _____ *For text communication to occur, please accept the disclosure below:	❒Appointment reminder ❒Other _____
❒For **email and/or text communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication as selected.	
❒Photo of patient received by patient or legal guardian ❒Photo taken by staff (Example: pre/post procedure) ❒Other _____	❒May be posted in office ❒May be posted on website ❒Other _____

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer bed protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

Patient Name _____ Date _____

Patient or Parent / Guardian Signature_____

*Description of Personal Representative's Authority (attach necessary documentation)
Revised Oct 2014

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Office Policies

We are happy you have chosen us to provide you and your family with excellent dental care. It is our sincere goal to give our patients a high quality and pleasant dental experience. Please sign below that you have read and understand all of our office policies. If you have any questions, please don't hesitate to ask one of our team members

Our Policy for Handling Your Insurance:

Because each plan is different, we may not have all the details of your particular insurance benefits. Since your insurance policy is a contract between you and your carrier, you are responsible for knowing the details of your particular policy and we encourage you to contact them directly with any questions. As a courtesy, we file to your primary insurance company. Insurance policies generally cover only a portion of the total treatment cost (due to coinsurance as well as "usual, customary and reasonable fees" established by the insurance company). We will ESTIMATE your patient portion that will be due at the time services are rendered. But you are responsible to pay any balance not paid by your insurance company within 60 days of rendered services.

Our Financial and Payment Policies:

Unless prior arrangements have been made, your patient portion is expected to be paid in full at the time services are rendered. We accept Visa, MasterCard, Discover, and American Express as well as Cash or Check. As a service to our patients we also accept Care Credit, to those who qualify. These plans provide you with many payment options, including interest free options. A charge of $25.00 will be added to your account for any returned check.

Appointments:

In order to provide quality dental care in an efficient manner, we ask that you give us at least two business days' notice of a cancellation or to reschedule your appointment. We will make every effort to see you at your appointed time. If you are running late for your appointment we may have to reschedule due to time constraints and other scheduled patients.

A deposit of $50.00 will be required for scheduling treatment that requires appointment times of 1 hour and 30 minutes or more and a $50.00 deposit will be required to schedule Scaling and Root Planing Procedures. Broken appointments represent a cost to us; therefore, cancellations with less than 2 business days' notice are subject to a $50.00 charge to the patients account.

_____ By Initialing, I acknowledge the $50.00 cancelation policy as outlined above.

Patient Name _____ Date _____

Patient or Parent / Guardian Signature_____