**William S. Woodworth, D.D.S.**

*Thank you for trusting us with your dental care. We will do our best to provide you with quality care. If you have any questions please do not hesitate to contact us.*

*"A smile is a little thing that makes a big difference!"*

**NEW PATIENT PACKET** - Welcome - Please complete all information.

Date:_____

Name:_____ Birthdate:_____ Male ____ Female ____

**How do you wish to be addressed *(what do your friends call you?)*:**_____

(Circle one) Minor Single Married Divorced Widowed Full Time Student? Y N School/College Name_____

Mailing Address_____City,_____State_____Zip_____

Mobile Phone_____ Email_____

Will you accept text messages? Y N Landline _____

Patient Employer_____Occupation_____Work Phone_____

Social Sec. No._____Spouse or Guardian Name_____ Phone_____

In case of emergency who should we contact_____Phone_____

**Who should we thank for referring you to our practice?_____**

**Responsible Party & Insured Party Information:**

**Name of Person Responsible for this Account**:_____Relation to Patient_____

Address:_____Home Phone:_____

Social Sec. No.:_____Employer:_____Ins ID #_____

Dental Insurance Co.:_____Group ID:_____Ins Phone:_____

Does your employer offer FSA or HSA benefits?_____Do you need additional information regarding benefits? Y N

**Insurance Information**

Name of Insured:_____Relation to Patient:_____

Date of Birth:_____Social Sec. No.:_____

Employer:_____ Dental Insurance Co.:_____Group ID:_____

Ins Phone:_____Ins ID #_____

**Additional/Secondary Insurance**

Name of Insured:_____Relation to Patient:_____

Date of Birth:_____Social Sec. No.:_____

Employer:_____ Dental Insurance Co.:_____Group ID:_____

Ins Phone:_____Ins ID #_____

**Assignment & Release**

I certify that I, and/or my dependent(s) have insurance coverage with (name insurance company)_____and assign directly to Dr. William S. Woodworth all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named dentist may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____ _____ _____ _____

***Signature*** of Patient, Parent or Guardian Printed Name Relationship to Patient Date

**Woodworth Family Dentistry – Dental History Review**

Name:_____ Date: _____

***Please indicate (by circling Yes or No) next to each of the following dental concerns that apply to you:***

| ***What brought you in today?*** |
|---|

| | | | | | |
|---|---|---|---|---|---|
| Tooth pain or discomfort when chewing | *Yes* | *No* | Sensitivity to hot, cold or sweet | *Yes* | *No* |
| Jaw pain | *Yes* | *No* | Headaches, ear ache, neck pain | *Yes* | *No* |
| Grinding or clenching teeth | *Yes* | *No* | Teeth or fillings breaking | *Yes* | *No* |
| Loose, tipped or shifting teeth | *Yes* | *No* | Bleeding, swollen or irritated gums | *Yes* | *No* |
| Dry mouth | *Yes* | *No* | Bad breath or bad taste in your mouth | *Yes* | *No* |
| Cigarette, smoke or pipe smoking | *Yes* | *No* | Blisters on lips or mouth | *Yes* | *No* |
| Mouth breathing | *Yes* | *No* | Fingernail biting | *Yes* | *No* |
| History of Periodontal treatment | *Yes* | *No* | Snoring | *Yes* | *No* |

| ***If you could change your smile, you would:*** | | | ***Do you have any of the following?*** | | |
|---|---|---|---|---|---|
| Remove staining or discoloration | *Yes* | *No* | Partial dentures | *Yes* | *No* |
| Make it brighter | *Yes* | No | Braces | *Yes* | *No* |
| Replace black fillings with tooth colored fillings | *Yes* | No | Periodontal/Gum Treatments | *Yes* | *No* |
| Close spaces | *Yes* | No | Dentures | *Yes* | *No* |
| Repair chipped teeth | *Yes* | No | Other Mouth or Oral Healthcare treatments we need to be aware of? | | |
| Repair missing teeth | *Yes* | No | | | |
| Replace old crowns that don't match | *Yes* | No | Current Home Care Routine: | | |
| Make it straighter | *Yes* | No | Are you brushing? | How many times per day? | |
| Have a smile makeover | *Yes* | No | Are you flossing? | How often? | |
| Any other dental concerns/details you'd like us to address? | | | Do you require premedication for dental treatment? | *Yes* | *No* |
| **Do you experience stress or anxiety when you visit a dental office? Yes No** | | | Have you experienced any complications associated with dental treatment? Yes No | | |

| | |
|---|---|
| Name of your previous dental provider: | Phone Number: |
| Date of last visit (approximately): | Date of Last Films: |
| Why did you leave your previous dentist? | |
| Are you usually numb for dental treatment (fillings and restorative work)? | |
| Have you ever experienced any complications associated with dental treatment? If yes, please explain: | |

On a scale of 1-10 with 10 having the highest rating: How important is your dental health to you? 1 2 3 4 5 6 7 8 9 10

Where would you rate your current dental health? Poor Fair Good Very Good

What is the most important thing to you about your dental visit?_____

*NYS has mandated that all prescriptions be e-prescribed (electronically transmitted to the pharmacy of your choosing) beginning March 27, 2016. Please inform our office manager if at any time you choose to elect another pharmacy to receive necessary medications. Thank you for your cooperation.*

**Which pharmacy do you use for prescribed medications?_____Location:_____**

| **Emergency contact not residing with you:** |
|---|
| Name: |
| Relationship: |
| Phone No.: |

**Woodworth Family Dentistry** - **Health Information**

Patient Name:_____ Date of Birth:_____ Today's Date:_____

*Although dental professionals 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 the care of a Physician now? ○Yes ○No ○N/A Physician's Name – Practice Name_____

Have you ever been hospitalized or had a major operation? ○Yes ○No ○N/A

Any major operations – please list and approximate dates:_____

Are you on a special diet? ○Yes ○ No Do you use any form of tobacco?_____

Have there been any changes in your general health in the last year? ○Yes ○ No

Women: Are you? Pregnant ○ Nursing ○ Taking Oral Contraceptives? ○Yes ○ No Name_____

| ***Do you have allergies to any of the following?*** | | ***Please list medications – Over the Counter or Prescribed. Please also note what condition the medication is treating. We can copy any lists provided.*** |
|---|---|---|
| Aspirin | *Yes No* | |
| Penicillin | *Yes No* | |
| Codeine | *Yes No* | |
| Metal | *Yes No* | |
| Latex | *Yes No* | |
| Local Anesthetics | *Yes No* | |
| Other | | |

| ***Do you have, or have you ever had, any of the following?*** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Aids/HIV Positive | Y N | Arthritis | Yes No | **Artificial Heart Valve*** | **Y N** | **Artificial Joint*** | **Yes No** |
| Asthma | Y N | Blood Disease | Y N | Breathing Problems | Yes No | Bruise Easily | Y N |
| Cancer | Yes No | Chemotherapy | Y N | Chest Pains | Y N | Cold Sores | Y N |
| Congenital Heart Disorder | Y N | Cortisone Medicine | Yes No | Diabetes | Y N | Drug addiction | Y N |
| Emphysema | Y N | Epilepsy of Seizures | Y N | Excessive bleeding | Yes No | Excessive Thirst | Yes No |
| Fainting Spells or Dizziness | Y N | Frequent Cough | Y N | Frequent headaches | Y N | Glaucoma | Y N |
| Hay Fever | Yes No | Heart Attack/failure | Yes No | **Heart Murmur*** | **Y N** | **Heart Pace Maker*** | **Y N** |
| Heart Trouble/Disease | Y N | Hepatitis A, B or C | Y N | High Blood Pressure | Yes No | Hives or Rash | Y N |
| Kidney problems | Y N | Liver Disease | Y N | Low blood pressure | Y N | Lung Disease | Yes No |
| **Mitral Valve Prolapse*** | **Y N** | Pain in Jaw Joints | Y N | Psychiatric Care | Y N | Radiation Therapy | Y N |
| Recent weight loss | Yes No | Rheumatism | Yes No | Scarlet fever | Yes No | Shingles | Y N |
| Sinus trouble | Y N | Stroke | Y N | Thyroid disease | Y N | Tonsillitis | Yes No |
| Tumors or Growths | Y N | Ulcers | Y N | Angina | Y N | Anemia | Y N |

***Condition may require medication. Please advise provider.***

Have you had any serious illness not listed above? Please specify._____

Comments:_____

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I will inform my dentist of any change in my health and/or medications. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child or me during the period of such dental care to third party payers and/or health practitioners. I also authorize to have photographs of my face, jaws and teeth taken. I understand that these items will be used as a record of my care, and may be used for educational purposes.

_____

Date Signature of Patient, Parent or Guardian

**Woodworth Family Dentistry**

Welcome! Thank you for selecting us as your dental providers. Our goal is to provide you with optimal dental care. We want you to feel as comfortable as possible throughout our relationship. We encourage you to ask questions and to be involved with treatment discussions. This includes understanding your treatment plan as well as the corresponding financial policy.

Financial Agreement:

Patients are expected to pay for our services at the time they are rendered. Our patients with dental insurance are expected to pay their estimated co-pay and deductible at time of service.
Payments may be made using cash, check, VISA, Mastercard and/or Discover.

All returned checks will incur a $30 processing fee and the discount benefits will no longer be rendered against your account.

Additional Information for our Insured Patients

As a courtesy to our insured patients, we submit claims to your insurance company as a complimentary service. We always advocate on your behalf in helping you receive your maximum allowable benefits. In order to do this we need your insurance card and/or policy number with you on your first visit and updates every calendar year (remember your plan may not run Jan – Dec). While we do our best to verify dental benefits prior to your visit, this does not guarantee coverage or payments. The contracts with benefit providers is between you, your employer and the insurance company selected.

Please understand:

Dental insurance isn't really insurance (a payment to cover the cost of a loss) at all. It is actually a monetary benefit, typically provided by an employer, to help their employees pay for routine dental services. The employer usually buys a plan based on the amount of the benefit and how much the premium costs per month. Most benefit plans are only designed to cover a portion of the total cost of a person's necessary treatment. We tell our patients that dental insurance may be likened to a gift certificate with exclusions.

Due to constantly changing insurance contracts, benefits and deductibles, we are only able to approximate your insurance coverage. As a courtesy to you we will file your claim. If the insurance company pays less than expected, you will be responsible for the difference. If we haven't heard from the insurance provider in 90 days, we will forward the balance to you. Final responsibility rests with the person responsible for your account (Patients who accompany minor children are responsible for the charges incurred).

Payments for co-payments or other charges are due on the day services are rendered. We accept cash and/or checks. As an additional courtesy to our patients we also accept Visa, Mastercard, and Discover without fee adjustment.

If you have any questions about the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We are here to help you!

Dr. Woodworth's Dental Team

_____

Please sign Today's Date