MEDICAL HISTORY

Patient Name ____

Physician's Name______________________ Physician's Phone #__________________________

List any medications you are taking or have take in the past 3 months:

____

____

Have you taken aspirin recently? ________Do you smoke or use smokeless tobacco? _________

Allergies (Please Circle):

Aspirin	Erythromycin	Metals	Other:
Codeine	Jewelry	Penicillin	_____________________
Dental Anesthetics	Latex	Tetracycline	_____________________

Conditions (Please Circle + Explain):

Abnormal bleeding	Liver Disease	Artificial Joint
Allergies	Pace Maker	Recent Hospitalization
Anemia	Radiation Therapy	Hemophilia
Asthma	Seizures	Pregnant
Cancer (Chemo)	Sinus Problems	Hepatitis A, B, or C
Diabetes	Stroke	Do you have any other conditions?
Epilepsy	Thyroid Problems	___________________________________
High Blood Pressure	Tuberculosis	___________________________________
HIV/AIDS	Arthritis	___________________________________
Kidney Problems	Heart Trouble	___________________________________

Has your physician advised you to be pre-medicated with antibiotics before dental work? _____

Is there any information we should know about previous dental visits? ______________________

____

Signature Date

PATIENT REGISTRATION

Last Name___________________ First Name_____________________ Middle________________

Home Address_____________________________ City ____________________________________

State _____________ Zip ______________________Home Phone ___________________________

Cell Number ____________________________ E-Mail ____________________________________

Birth Date _______/ ________/ ________ Sex: Male / Female Social Security #_____________

Single ____ Married ____ Partnered ____ Widowed ____ Separated ____ Divorced ____

Patient Employed by____

Position____________________________________ How long held? _________________________

Business Address ____

Zip _________________ Phone ____

Spouse's Name ____

Birth Date _____________________ Social Security # __________________________________

Spouse employed by ____

Business address ____

Zip __________________ Phone ____

Other family members seen at this office ____

Emergency Contact Name ____

Emergency Contact Phone ____

Pharmacy ________________________________ Phone __________________________________

Services provided today will be paid by: Check ____ Cash ____ Visa/MC/Discover ____

Referred by _____________________ Purpose of Call ___________________________________

Do you have dental insurance? ________ Do you have secondary dental insurance? _________

Please present your insurance card(s) to the receptionist.

Patient's name ____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

Your privacy is important to us. We create information about you so we may provide you with quality care. We are committed to protecting this information. The Notice of Privacy Practices describes your rights with regard to your health information, as well as how we may use your health information, and how we must protect the confidentiality of your health information. This is a summary of the more detailed information contained in our Notice of Privacy Practices.

Your rights include: A right to inspect and request a copy of your treatment information; A right to request an amendment to your health information; A right to request restrictions on what information we use or how we disclose your health information; A right to receive an accounting of certain disclosures we have made of your health information; A right to receive a paper copy of our Notice of Privacy Practices. These rights do have special restrictions, so it is important that you read the full Notice of Privacy Practices.

We may also use your health information and/or treatment records to: Plan for your care; Help your health care providers communicate and work together to care for you; Submit bills to pay for your care; Help health care payers make sure services were actually provided; Help improve the quality of health care; Disclose information to certain officials or organizations where we may, or are, required to do so by law. Every person who may access your information is bound by our confidentiality requirements, as outlined in our Notice of Privacy Practices.

I have received the Notice of Privacy Practices.

Signature: ______________________________ Date: _____________________

BINDING ARBITRATION

All claims and disputes, arising from medical, dental and/or other treatment provided by W R Wauligman DDS Inc, are to be settled by binding arbitration in the state of Ohio. Any decision made through binding arbitration is legally binding and shall be considered final.

Signature: ___________________________ Date: _______________________

AUTHORIZATION OF DENTAL SERVICES

I hereby consent to the administration of medical, dental and/or other treatment. I further consent to the prescription of medications and/or testing as necessary or as may be deemed necessary. I am aware that smoking, alcohol and/or sugar consumption may negatively affect tissue health and restoration prognosis. I know I must follow my dentist's home care instructions and report to my dentist for regular examinations as instructed. I further understand that excellent home care, including brushing, flossing and the use of any other device recommended by my dentist is critical to the success of my treatment.

I promise to, and accept responsibility for failing to return to this office for examinations and any recommended treatment at least every 6 months. My failure to do so, for whatever reason, can jeopardize my oral health. Accordingly, I agree to release and hold my dentist harmless if my treatment fails as a result of not maintaining an ongoing examination and preventive maintenance routine by my dentist.

I am aware that the practice of dentistry and dental surgery is not an exact science and I acknowledge that no guarantees have been made to me concerning the success of treatment. Treatment failure and remedial procedures could also involve additional fees being assessed.

If an unforeseen condition arises in the course of treatment, which calls for the performance of procedures in addition to or different from those initially contemplated, I am aware that my dentist may advice an alternate treatment option.

I agree to be financially responsible for all charges for services rendered and materials utilized.

Signature: ____________________________ Date: ___________________

DENTAL INSURANCE INFORMATION

Patient Name ____

Primary Dental Insurance Coverage:

Subscriber Name and Address ____

Relation to Patient ____

Subscriber Soc Sec # ____________________ Subscriber Date of Birth _________________________

Group/Plan # _______________________ Subscriber ID # ___________________________________

Employer Name and Address ____

Dental Insurance Company Name and Claim Mailing Address _______________________________

Secondary Dental Insurance Coverage:

Subscriber Name and Address ____

Relation to Patient ____

Subscriber Soc Sec # ___________________ Subscriber Date of Birth _________________________

Group/Plan # __________________________ Subscriber ID # _________________________________

Employer Name and Address ____

Dental Insurance Company Name and Claim Mailing Address

Assignment of Benefits:

I authorize payment of dental benefits to the named provider of services rendered

____

Signature Date

Release of Information:

I authorize the release of any dental information pertaining to this claim

____

Signature Date

Please have the receptionist copy your dental insurance card(s).