

Jeffrey R. Wert, D.M.D., P.C.

Patient Registration Form

Date: _____
Patient Name: _____ Birthdate: _____ Sex: M F
Address: _____
Email Address: _____ Home Phone: _____
SSN: _____ - _____ - _____ Marital Status: **S M D W** Cell Phone: _____
Employer: _____ Work Phone: _____ Ext: _____
If student, School: _____ Grade: _____
Spouse/Parent Name: _____
Spouse/Parent Employer: _____ Phone: _____ Ext: _____
Emergency Contact: _____ Phone: _____

Person Responsible For Account

Name: _____ Relationship to Patient: _____
Address: _____ Phone: _____
Employer: _____ ID/SSN: _____
Insurance Company: _____ Group No: _____
Secondary Ins Co: _____ Policy Holder: _____
Relationship to Pt: _____ ID No.: _____ Group No: _____
Employer: _____

Dental History

Date of last dental visit: _____ Reason for visit: _____
Date of last cleaning: _____ Date of last x-rays: _____
Previous Dentist: _____ Reason for leaving: _____

Have you had any of the following?

Loose Teeth	Yes	No
Gum Pain/swelling	Yes	No
Bleeding when brushing	Yes	No
Gum/periodontal disease	Yes	No
Periodontal Surgery	Yes	No
Oral Surgery	Yes	No
Root Canal Treatment	Yes	No
Orthodontics	Yes	No
Click/noise in jaw	Yes	No
Pain in ear or jaw	Yes	No
Pain or difficulty chewing	Yes	No
Pain opening mouth	Yes	No
Treatment for TMJ	Yes	No
If child, suck thumb/finger?	Yes	No

Injury to head or mouth?	Yes	No
Describe: _____		
History of Headaches?	Yes	No
How frequently? _____		
Sensitivity? Cold Hot Sweet		
Do you have any of the following habits?		
Grind or clench teeth?	Yes	No
Bite nails?	Yes	No
Hold objects in mouth?	Yes	No
Breathe through mouth?	Yes	No
Smoke or chew tobacco?	Yes	No
Drink coffee or tea?	Yes	No

How often do you brush? _____ Type of toothbrush? _____ If child, does a parent help? _____
Do you floss? _____ If so, how frequently? _____ Fluoride taken in any form? _____
How do you feel about having dental treatment done? Have you ever had an uncomfortable experience? _____
Is there anything else we should be aware of? _____

Signature: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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 _____

Office Policies and Financial Agreement

It is our desire to provide the highest quality of dental care to everyone. The following is a statement of Dr. Jeffrey Wert's dental office's Policies and Financial Agreement. We ask that you please read, agree to, and sign before any treatment is rendered.

Regarding Insurance

Our goal is to maximize your insurance benefits. It is important to understand that the insurance contract is between the insurance company and you, the insured. Dental insurance was not designed to pay for all dental care. Treatment recommended by Dr. Jeffrey Wert and his associates is never based on what your insurance company will pay. Due to pending claims and patient privacy issues, we do not always know how much an insurance company has already paid to another office or specialist, and the balance remaining on a yearly maximum. Please be prepared to show your insurance card and driver's license at the time of your visit. It is the patient's / guarantor's responsibility to provide any new information regarding insurance. Our office will gladly submit your insurance claim to your insurance carrier, as a courtesy to you. At the time of treatment, the patient / guarantor is responsible for the estimated portion the insurance does not cover. If for some unforeseen reason your insurance carrier has denied or not made payment within 60 days, the patient / guarantor is responsible for the balance in full. _____ **(Initial)**

Payment Options

Cash, Check, MasterCard, Visa, Care Credit

3rd Party Financing

With prior approval, we are pleased to offer a choice of No Interest or Extended Payment Plans to qualified applicants through Care Credit. If you would like to make extended payments for services provided at our office, please ask any of our administrative team for assistance in filling out an application form. _____ **(Initial)**

Additional Charges

A fee of \$30 will be charged on all returned checks. _____ **(Initial)**

Cancellation Policy – 24 Hours' Notice

If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24 hours' notice. If less than 24 hours' notice is given, there will be a \$75 broken appointment fee per appointment that is cancelled or missed. Our office does not accept cancellations or changes in appointments via email, text, or after hours by voice mail; you **must** call during our normal business hours. This courtesy on your part will make it possible to give your appointment to another patient who needs to see the dentist or hygienist. _____ **(Initial)**

PRINT PATIENT NAME

PATIENT SIGNATURE

(PARENT / GUARANTOR signature if patient is a minor)

DATE

Jeffrey R. Wert, D.M.D., P.C.

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

Since Jeffrey R. Wert, D.M.D., P.C. is a HIPAA covered office, our office policy requires you to sign this acknowledgement. If you do not wish to sign this acknowledgement, we are not comfortable seeing you in our office and you will have to locate another dentist.

I, _____,

have received a copy of this office's Notice of Privacy Practices. A copy of this signed and dated Acknowledgement shall be as effective as the original. **My signature will also serve as a Protected Health Information (PHI) document release should I request documents be sent to other attending doctor / treatment facilities in the future.**

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but Acknowledgement could not be obtained because:

- _____ Individual refused to sign
- _____ Communication barriers prohibited obtaining the acknowledgement
- _____ An emergency situation prevented us from obtaining acknowledgement
- _____ Other (Please Specify)

Dr. Jeffrey R. Wert & Associates
Third Party Authorization

Here at our office we are committed to the protection of your personal information. In order to discuss your dental health and/or treatment plans with or release information to **third parties**, this form must be completed and signed. Please include the names of all individuals that you want to have access to your dental records and/or treatment plans. **If you do not want a third party contact(s) on file, please leave this form blank.**

Name: _____
Phone #: _____
Relationship: _____

Name: _____
Phone #: _____
Relationship: _____

I, _____, hereby authorize Dr. Wert & Associates to have verbal and/or written communication with the above stated individual(s). This authorization will remain in effect until I submit a written letter or email to Dr. Wert & Associates, terminating my consent.

Signature: _____ Date: _____