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

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)

_____