MEDICAL HISTORY AND CONSENT

Although dental personnel treat the area in and around your mouth, your mouth is a part of your entire body. Health conditions or problems that you may have or had, or medications that you may be taking, could have an important interrelationship with the treatment you will receive Thank you for answering the following questions.

Full Name:_____ Date _____

Allergies

Acrylics	Y	N
Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Other	Y	N

List other known allergies:

_____

_____

_____

_____

_____

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Gastrointestinal

Acid Reflux	Y	N
Gerd	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N

General

Current weight: _____ lbs

Height: _____ ft _____ in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
STD	Y	N
Knee/Hip Replacement	Y	N
Liver problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N

Hematological

Bleeding Problems	Y	N
Hepatitis	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory Problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea (shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Full Name: _____ Date _____

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (Ringing)	Y	N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N
Joint Replacement Date_____	Y	N
Osteoporosis	Y	N
Arthritis	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw Problems (TMJ?)	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontial Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N
Do you wear removable teeth	Y	N
Do you take or need antibiotics before dental procedures?	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N
How often? _____		
Has anyone told you that you snore?	Y	N

Social History

Do you smoke? Y N _____ packs a day

Do you use smokeless tobacco	Y	N
Do you consume alcoholic beverages?	Y	N

_____ Drinks per day/week/month

Do you use recreational drugs?	Y	N

1. Reason for visit: _____
2. When was your last dental visit? _____
3. How often do you brush your teeth? _____
4. What texture brush do you use? ☐ Soft ☐ Medium ☐ Hard

5.	Do your gums bleed while brushing?	Y	N
6.	Do your gums bleed when flossing?	Y	N
7.	Do you feel pain to any of your teeth when brushing or flossing them?	Y	N
8.	Are you teeth sensitive to hot, cold, sweet or sour foods/ liquids?	Y	N
9.	Have you noticed any loosening of your teeth?	Y	N
10.	Does food tend to become caught between your teeth?	Y	N
11.	Do you have any sores or lumps in or near your mouth?	Y	N
12.	Have you ever experienced any of the following problems in your jaw?		
	a. Clicking?	Y	N
	b. Pain (joint, ear, side of face)?	Y	N
	c. Difficulty in opening or closing?	Y	N
	d. Difficulty in chewing?	Y	N
13.	Have you had any head, neck or jaw injuries?	Y	N
14.	Do you have frequent headaches?	Y	N
15.	Do you clench or grind your teeth while awake or asleep?	Y	N
16.	Do you bite your lips or cheeks frequently?	Y	N
17.	Have you ever had:		
	a. Orthodontic treatment (braces)?	Y	N
	b. Oral surgery?	Y	N
	c. Gum treatment?	Y	N
	d. Your teeth ground or the bite adjusted?	Y	N
	e. Worn a bite plate or appliance?	Y	N
18.	Are you satisfied with the appearance of your teeth?	Y	N
19.	Have you ever had an upsetting experience in the dental office?	Y	N
20.	Is there anything about having dental treatment that bothers you?	Y	N

Women Only

1.	Are you pregnant or think you may be pregnant?	Y	N
2.	Are you nursing?	Y	N
3.	Are you taking birth control pills?	Y	N

Full Name:_____ Date _____

MEDICAL HISTORY AND CONSENT

List any medications you are taking:

Medication Dosage/Freq. Prescriber Reason

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List any surgeries or hospitalizations you have had:

Date(year) Surgery Surgeon Reason

_____
_____
_____
_____
_____
_____

List and detail any medical condition or history not listed above:

_____
_____
_____
_____

Primary Physician's Name _____ Physician's phone #:_____

Are you under the care of other physicians? If so, please list:

Physician Phone # Reason

_____
_____
_____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes WYO ORTHO to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize WYO ORTHO to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that WYO ORTHO choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by WYO ORTHO. To be the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/the patient's health. It is my responsibility to inform the dentist office of any change in medical health or status.

Consent (adult):

Name of Patient _____ _____ Date _____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ Date _____

Signature of Parent/Guardian

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name_____

Address _____

Telephone_____ Email_____

Patient#_____Social Security # _____

SECTION B: TO THE PATIENT - Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice accompanies this Consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice at any time by contacting:
Contact Person: Linda Dressler
Telephone: 307-237-1801 Fax: 307-237-3686
E-mail: dds@hilltopfamilydentalwy.com
Address: 3090 Talon Dr Casper WY 82604

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person above. Please understand that your revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____ have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name _____

Relationship to Patient_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Includes completed Consent in the patient's chart.

WYO ORTHO

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign this Acknowledgment*

I, _____ have received a copy of this office's Notice of Privacy Practices.

_____

Patient Name

_____

Signature

_____

Date

List person/persons you permit WYO ORTHO to release information to:

_____

_____

_____

_____

*** For Office Use Only ***

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

( ) Individual refused to sign

( ) Communication barriers prohibited obtaining the acknowledgment

( ) An emergency situation prevented us from obtaining acknowledgment

( ) Other (please specify)

_____

_____

Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions, we'll be glad to help. (Please print)

WYO ORTHO ***3090 Talon Dr, Casper WY 82604*** ***307-237-1801***

PATIENT INFORMATION

Name_____ [ ] Dr. [ ] Mr. [ ] Ms. [ ] Rev. [ ] Other:_____
First MI Last

Address _____ Occupation _____ [ ] Male [ ] Female

City _____ State_____ Zip _____ Hm# ( )_____

Employer_____ Wk# ( )_____ Ext._____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated Cell# ( )_____

DOB:_____/_____/_____ SSN# _____ Email:_____

Spouse's Name _____
First MI Last (if different)

Spouse Employer _____ Wk# ( ) _____ Ext._____

Is patient a full time student? [ ] No [ ] Yes: Name of School _____

RESPONSIBLE PARTY (if different that patient)

Name _____
First MI Last

Address _____

City _____ State _____ Zip _____

Hm# ( ) _____

Wk# ( ) _____

DOB:_____/_____/_____

SSN# _____

Relationship:_____

YOUR PREFERENCES

Do you prefer appointment reminders by:
[ ] Email [ ] Phone [ ] Text
Do you prefer to receive calls from our office at:
[ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you?

_____

Emergency Contact Info:

_____

INSURANCE INFORMATION

MEDICAL INSURANCE:

Subscriber's Name _____ Relationship to Patient _____

DOB:_____/_____/_____ Subscriber's SSN# _____ Employer _____

Insurance Company _____ Policy # _____ Group #_____

SUPPLEMENTAL INSURANCE (DENTAL):

Insured Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB:_____/_____/_____ Subscriber's SSN# _____ Employer _____

Insurance Company _____ Group # _____ Eff. Date: ____/_____/_____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Insured Name _____ Relationship to Patient _____

Address _____ City _____ State _____ Zip _____

DOB:_____/_____/_____ Subscriber's SSN# _____ Employer _____

Insurance Company _____ Group # _____ Eff. Date: ____/_____/_____

CONFIDENTIAL

AUTHORIZATION, RELEASE AND AGREEMENT TO PAY FOR SERVICES RENDERED

I authorize the dentist to release any information including the diagnosis and records of the treatment or examination rendered to me during the period of such dental care to third party payers and/or other health providers.

I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me.

I understand that my medical and/or dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

Signature of Insured_____ Date _____

WYO ORTHO FINANCIAL OFFICE POLICY

1. Payment is due at time of treatment.
2. We accept cash, check, Visa, MasterCard or Discover.
3. We offer outside financing through CareCredit and CitiBank.
4. Accounts not paid in full by the end of the month will be assessed a billing fee of 1.75% per month (21% annual).
5. If you have insurance, we will file your claims as a courtesy. However, any balance not paid by your insurance is your responsibility.
6. There will be a charge for missed or canceled appointments without 24 hour notice.

Person Responsible for Account _____ Date _____

I, the undersigned client/guardian, agree to pay for all services rendered and/or goods sold to me or my ward immediately upon demand. I further agree that in the event of non-payment of any amounts due under this agreement I will pay interest thereon at the rate of 1.75% per month and pay all reasonable attorney fees and court costs that may be incurred. I agree that in the event this agreement is assigned to an agency for collection I promise to pay an additional collection fee of 35% of the unpaid balance due.

Parent or Responsible Party_____ Relationship to Patient _____