NEW PATIENT INFORMATION

Personal Information:

Date:_____

Title:_____ Name:_____ Sex: ___(Male) ___(Female)
First, Middle Initial Last

Date of Birth: _____ Social Security #: ____-___-_____ E-mail: _____

Home Address: _____
Street City State Zip

Home Phone: _____ Work Phone: _____Cell: _____

Who may we thank for the referral:_____ Preferred Dentist: _____

Emergency Contact (*Name*):_____ Contact Phone: _____

Employment Information:

Employer: _____ Present Position/Occupation: _____

Employer's Address: _____
Street City State Zip

Insurance Information:

As a courtesy, we will accept payment of benefits directly from your insurance company. The part of our fee that is not covered by insurance is due and payable at the time of treatment. Please fill in all information accurately and completely.

Insurance Company: _____Group #: _____ Employee ID#: _____

Insurance Co. Address: _____ Ins. Co. Phone: _____

Billing Information of Responsible Party:

Insured's Name: _____ Soc. Sec. #: ____-___-_____ Birth Date: _____
First MI Last

Insured's Address: _____ E-mail:_____
Street City Zip

Insured's Home Phone: ____-____-_____ Work Phone: ____-____-_____ Cell: ____-____-_____

Insured's Employer: _____ Address: _____
Street City Zip

PATIENT MEDICAL HISTORY

Patient Name: _____ Physician's Name: _____Phone: _____
Pharmacy Name:_____ Pharmacy Phone Number:_____

Please be aware that any health problems that you may have, or any prescribed or over-the-counter medications and dietary supplements that you may be taking could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions fully and accurately.

Are you under a physician's care now?	Y__ N__
Have you been hospitalized or had a major operation in the last 5 years?	Y__ N__
Have you ever had a serious head or neck injury?	Y__ N__
Are you taking any medications, pills or drugs of any kind?	Y__ N__
Are you on a special diet?	Y__ N__
Do you smoke now, or have you smoked in the past?	Y__ N__
Do you use controlled substances?	Y__ N__

Women: are you pregnant? Y__ N__ Nursing? Y__ N__ Taking oral contraceptives? Y__ N__

Are you allergic to any of the following:
__Latex __Aspirin __Penicillin __Codeine __Acrylic __Metals __Local Anesthetics __Other: _____

Do you have, or have you had, any of the following: (* *conditions require premedication*)

_ AIDS/HIV positive	_ Alzheimer's disease	_ Anaphylaxis
_ Anemia	_ Angina	_ Arthritis/Gout
_ Artificial Heart Valve*	_ Artificial Joint*	_ Asthma
_ Any blood disease	_ Blood transfusion	_ Breathing problems
_ Bruise easily	_ Cancer	_ Chemotherapy
_ Chest pains	_ Cold sores/fever blisters	_ Congenital heart disorder
_ Convulsions	_ Cortisone medication	_ Diabetes
_ Drug Addiction	_ Easily winded	_ Emphysema
_ Epilepsy or Seizures	_ Excessive bleeding	_ Excessive thirst
_ Fainting spells/dizziness	_ Frequent coughing	_ Frequent diarrhea
_ Frequent headaches	_ Genital herpes	_ Glaucoma
_ Hay fever	_ Heart attack/failure	_ Heart murmur
_ Heart pacemaker*	_ Heart disease	_ Hemophilia
_ Hepatitis A, B or C	_ Herpes	_ High blood pressure
_ Hives or rash	_ Hypoglycemia	_ Irregular heartbeat
_ Kidney problems	_ Leukemia	_ Liver disease
_ Low blood pressure	_ Lung disease	_ Mitral valve prolapse
_ Pain in jaw joints	_ Parathyroid disease	_ Psychiatric care
_ Radiation treatments	_ Recent weight loss	_ Renal dialysis
_ Rheumatic fever*	_ Rheumatism	_ Scarlet fever

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Do you have, or have you had, any of the following: (*continued*)

_ Shingles	_ Sickle cell disease	_ Sinus trouble
_ Stomach/intestinal disease	_ Stroke	_ Swelling of limbs
_ Thyroid disease	_ Tuberculosis	_ Tumors or growths
_ Ulcers	_ Venereal disease	_ Yellow jaundice

Have you ever had any other serious illness not listed above? Y__ N__

Please list all medications you are currently taking:_____

_____

PATIENT DENTAL HISTORY

Reason for today's visit: _____Date of last visit: _____ Date of last X rays: _____

Former Dentist's name: _____Phone Number: _____

Are you satisfied with your smile? Y__ N__ With the whiteness of your teeth? Y__ N__

How often do you brush? _____ How often do you floss? _____

Indicate if you have, or are aware of any of the following:

_ Bad breath	_ Bleeding gums	_ Blisters on lips or mouth
_ Burning sensation on tongue	_ Chewing on one side of mouth	_ Cigarette smoking
_ Clicking or popping of jaw	_ Dentures/Partial dentures	_ Dry mouth
_ Finger nail biting	_ Food collection between teeth	_ Grinding of teeth
_ Gums swollen or tender	_ Jaw pain or tiredness	_ Lip or cheek biting
_ Loose teeth or broken fillings	_ Mouth breathing	_ Mouth pain during brushing
_ Orthodontic treatment	_ Periodontal treatment	_ Sensitivity to hot/cold

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To the best of my knowledge, the questions on this form have been understood by me and accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status. I will not hold my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Patient Signature _____ Dentist Signature _____

Date _____ Date _____

The information documented in this form will be handled strictly according to HIPAA guidelines and remains strictly confidential. It will not be shared with third parties without the consent of the patient.

OUR FINANCIAL POLICY

Thank you for choosing Watergate Dental Associates (WDA) to provide your dental care. Our primary mission is to deliver the best and most comprehensive dental care available. To make the cost of this optimal care as easy and manageable for our patients as possible, we offer several payment options:

A. Cash, Check, VISA, MasterCard, or American Express.
B. Convenient payment plans can be arranged on an individual basis for cases exceeding $500.00.

Please place your initials by each to indicate that you have read and understood the terms:

____ Watergate Dental Associates requires payment in full for all services rendered by WDA prior to the completion of your treatment. If you choose to discontinue your ongoing care before treatment is complete, any refund will be determined upon review of your case.
____ I understand that all unpaid balances 30 days overdue will incur a service charge of 1.5% per month.
____ I agree that in the event of any default of this account, and if a suit is brought as a result, WDA shall be entitled to collect in such proceedings all reasonable costs and expenses of said lawsuit including, but not limited to, reasonable attorney's fees. I understand that in the event of default, an administrative fee of not less than $50.00 or 30% of the outstanding balance, whichever is greater, shall be applied to the account.
____Please remember that your insurance contract is between you and your insurance company, and your total balance will remain your sole responsibility. As a courtesy to our patients with insurance, we will file your insurance claim. You are expected to pay your deductible and/or estimated portion of the balance as services are rendered. Watergate Dental Associates will only pursue insurance claim payments for 45 days, after which we will be happy to assist you in contacting your insurance company and providing you with the necessary information. We make every effort to give you an accurate estimate of what your portion of the fees will be, based on information provided to us. However, we have no way to guarantee the actual terms of your policy. Any balance remaining after the insurance company pays its portion will remain your responsibility. Any disputes regarding reimbursement are between you and your insurance carrier. You are ultimately responsible for knowing and understanding your policy, its benefits, exclusions and limitations.
___ Acceptance of partial payment for treatments exceeding $500.00 and needing multiple visits will require alternative payment plan arrangements in advance. If, for any reason, your insurance does not pay for the services rendered by Watergate Dental Associates, you, the patient, are solely and fully responsible for the entire balance.
___ If you have any questions about your insurance, please let us answer them before treatment begins. Otherwise, we will assume that you are familiar with your dental plan coverage and limitations. Please note that dental insurance is very different from medical insurance, and most dental procedures require a co-payment.
___ A fee of $100.00 will be charged for missed appointments or cancellations without a **48** hour notice.
___ A $35.00 will be assessed for all returned checks.

I have read and I understand the entire financial policy.

_____ _____ _____

Patient or Guardian Signature Date Patient or Guardian Name (Please print)

NOTICE OF PRIVACY PRACTICES AND AUTHORIZATIONS

The privacy of your health information is important to us. This notice describes how health information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

Our Legal Duty:
We are required by applicable Federal and State law to maintain the privacy of your health information. We are also required to give you this Notice about our Privacy Practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice (*along with the more detailed full version available upon request).*

We reserve the right to change our privacy practices and terms of this office at any time, provided such changes are permitted by applicable law. We reserve the right to make these changes applicable to all the health information that we maintain, including the health information that we received before we made the changes. The current Notice and any new Notice is available to you upon request.

Uses and Disclosures of Health Information:
We use and disclose health information about you only for the purposes of necessary treatment, payment and healthcare operations.

Your Authorization:
In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to anyone for any purpose. If you give us this authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while in effect. Without your explicit written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

Further Authorizations:
I authorize the use of this form for all my insurance submissions.

I authorize the release my relevant personal information to all my insurance carriers.

I understand that I am fully responsible for my bill for all services rendered.

I authorize my doctor and Watergate Dental Associates to act as my agent in helping me obtain payment from my insurance carrier.

I authorize payment of the insurance benefits directly to my doctor.

I permit a copy of this authorization to be used in place of the original.

Name: _____ Signature: _____ Date: _____
Please print

Watergate Dental Associates

Oral Cancer Screening Consent

For many types of cancer, **early detection** is critical for increasing the chances of successful treatment outcomes. Oral cancer, **the fastest growing type of head and neck cancer**, is no exception. In the United States, it is estimated that **one person dies every hour** from oral cancer, and yet many of these deaths could have been prevented with earlier detection and prompt intervention.

There are many known risk factors associated with a higher chance of developing oral cancer. These include increased age as well as lifestyle habits such as drinking and smoking. In all sexually active adults, regardless of age, the rapidly increasing rates of Human Papilloma Virus (HPV) transmission represent an emerging category of risk factors. HPV has been shown to increase a person's chances of developing oral cancer. Furthermore, it is estimated that nearly 20 million Americans are currently infected with HPV.

The entire team here at Watergate Dental Associates is committed to educating our patients about the risk factors associated with oral cancer. Along with our routine oral cancer examination, which is performed at every dental check-up, we are pleased to introduce **VELscope** (Visually Enhanced Lesion Scope). VELscope, a **painless** light system, utilizes the most recent technological advancements in enhanced early detection of tissue changes associated with oral cancer. Thus, it allows for the earliest possible detection of oral cancer. Like mammograms and PSA tests, VELscope is an effective system for routinely screening patients for cancer and pre-cancerous tissue changes. We are happy to offer this potentially life-saving service to all of our patients.

This enhanced examination is recognized by the American Dental Association code D0431; however this exam might not be covered by your insurance. The fee for this enhanced examination is $45.

☐ **Yes**. I want to have the VELscope exam at this time and once yearly thereafter.

☐ **No**. I would prefer not to have the VELscope exam at this time.

Print Name _____

Signature _____ Date _____