Medical History Insurance Update 2021

Today's Date: _____

Name: _____
Last First M.I.

Preferred Name: _____

Address: _____
PO Box (if applicable)Physical Address Required

_____
City State Zip Code

Birthdate: _____

Medical Physician's Name and Phone #
Name_____
Phone #_____
Date of Last Visit: _____

Primary Contact Information:

We Offer Text and Email Confirmation

Cell: _____

Email: _____

Emergency Contact Information:

Name: _____

Cell: _____

Have you had any of the following? Circle YES or NO

YES/NO Abnormal Bleeding	***YES/NO*** High Blood Pressure	***YES/NO*** Heart Pacemaker	***YES/NO*** HIV +/AIDS
YES/NO Diabetes	***YES/NO*** Difficulty Breathing	***YES/NO*** Asthma	***YES/NO*** Stroke
YES/NO Drug/Alcohol Abuse	***YES/NO*** Emphysema	***YES/NO*** Ulcers/Colitis	***YES/NO*** Broken Jaw
YES/NO Glaucoma	***YES/NO*** Sinus Problems	***YES/NO*** Kidney Disease	***DENTAL INFORMATION***
YES/NO Artificial Valves	***YES/NO*** Tuberculosis	***YES/NO*** Liver Disease	***YES/NO*** Implants
YES/NO Psychiatric Problems	***YES/NO*** Venereal Disease	***YES/NO*** Hepatitis A/B/C	***YES/NO*** Ortho
YES/NO Heart Attack	***YES/NO*** Epilepsy/Seizures	***YES/NO*** Smoke/Tobacco Use	***YES/NO*** Dry Mouth
YES/NO Fainting	***YES/NO*** Congenital Heart Defect	***YES/NO*** Periodontal Disease/Surgery	
YES/NO Arthritis	***YES/NO*** Artificial Joints	***YES/NO*** Thyroidism Hypo or Hyper? _____	
YES/NO Cancer/Chemotherapy Date _____		***YES/NO*** Heart Surgery Date: _____	

YES/NO Other Health Problems:_____

Any Recent Surgery? _____

Are you ALLERGIC to any of following? Circle YES or NO

YES/NO Aspirin ***YES/NO*** Codeine ***YES/NO*** Penicillin ***YES/NO*** Erythromycin ***YES/NO*** Tetracycline

YES/NO Latex ***YES/NO*** Dental Anesthetics ***YES/NO*** Metals ***YES/NO*** Other:

Please list OTHER DRUG ALLERGIES: _____

For Women:

Are you taking birth controls pills? ☐yes ☐no

Are you Pregnant? ☐yes ☐no Week# _____

Are you nursing? ☐yes ☐no

Please List All Medications You Are Currently Taking:

_____

Account Information: Only Complete if changed

Person Responsible For Account: (*if minor; parent who attends child today)*
Name: _____
Last First M.I.
Address: _____
PO Box (If Applicable) Physical Address Required
_____
City State Zip Code

Insurance Information: (Complete if information has changed)
Insured's Name: _____
Insured's Employer:_____
Employer Address:_____
Insured's BirthDate: _____/_____/_____ SS# _____/_____/_____
Insured's ID _____
Insurance Co. Name: _____
Insurance Address: _____
Complete address (PO Box or Physical, City, State, Zip Code)
Group # _____ Phone # (_____) _____

Basic Information About How Our Office Handles Insurance:
As a courtesy to our patients, our office will file all dental insurance claims and give assistance to make sure that your insurance pays to the maximum. We must have all pertinent insurance information. ***Our office is not a NETWORK PROVIDER FOR ANY INSURANCE PLAN.***
Any unpaid insurance balance over **45 days** becomes the patient responsibility. All co-payments are due **at Time of Service**. If you have any questions, please see Insurance Billing. **Initial: _____**

No Insurance? No Problem!
Ask about our Dental Health Club Plan!
Yearly Membership with Savings
No Maximums, No Deductible

WDW Cancellation Policy: Our desire is to make appointments as comfortable & convenient as possible. If it becomes necessary to cancel an appointment, we request to be notified 1 business day before time of appointment. This allows us to schedule conveniently for the patient filling the cancellation. Patients breaking or canceling appointments without this 1 business day notice will be charged $50.00. WDW reserve the right to make exceptions, and forego penalties for short-cancellations with compassionate rationale. These may include but are not limited to: sickness, sudden medical situations, or the death of a close family member. **Initial: _____**

I understand the information I have given today is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my medical status.
Signature _____ Date: _____