Account Information: 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:

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: _____

New Patient Welcome To Our Office 2021

Today's Date: _____
Reason for visit today? _____

Patient Name: _____ _____ ____
(Last) (First) (M)

Preferred Name: _____

Home Address:

_____
PO Box (if applicable) Physical Address Required

_____
City State Zip Code

Birthdate: _____/_____/_____ SS# _____-_____-_____

Circle: Male Female Age: _____
Single Married Divorced Widowed Separated

Other Family Members Seen By Us: _____
Circle Last Dental Cleaning: 6mths 6mths-1yr 1-2yrs over 2yrs

Contact Information: (We offer Text and Email Confirmation)
Home# (_____)_____ Cell# (_____)_____ Work# _____
Email Address: _____@_____

Whom May We Thank For Referring You? Internet , Postcard In Mail,
Friend/Relative Name: _____

Medical
Physicians Name: _____
Phone: (_____) _____
Date of Last Visit? _____/_____/_____

Emergency Contact:
Name: _____
Relation: _____
Phone #: _____

Medical History: Circle Yes or No

Yes/No Abnormal Bleeding
Yes/No Broken Jaw
Yes/No Diabetes
Yes/No Drug/Alcohol Abuse
Yes/No Emphysema
Yes/No Hepatitis A/B/C
Yes/No HIV +/AIDS
Yes/NoTuberculosis
Yes/No Epilepsy/Seizures
Yes/No Psychiatric Problems
Yes/No Congenital Heart Defect
Yes/No Artificial Joints
Yes/No Artificial Valves
Yes/No Dental Implants
Yes/No Orthodontics
Yes/No High Blood Pres.
Yes/No Ulcer/Colitis
Yes/No Difficulty Breathing
Yes/No **Stroke**
Yes/No Asthma
Yes/No Sinus Problems
Yes/No Kidney Disease
Yes/No Liver Disease
Yes/No Arthritis
Yes/No Venereal Disease
Yes/No Gum Disease
Yes/No Glaucoma
Yes/No Fainting
Yes/No Dry Mouth

Yes/No Thyroidism Hyper or Hypo? _____
Heart Surgery/Pace Maker **Heart Attack** Date _____
Yes/No Smoke/Tobacco Use Other Health Prob. _____
Cancer/Chemotherapy (if so, When _____
Any Recent Surgery's: _____

For WOMEN: Are you taking birth control pills? ___
Are You **PREGNANT**? ☐Yes ☐No Week # _____
Are You Nursing? ☐Yes ☐No

Are You **ALLERGIC** to any of the following? Yes / No
☐Aspirin ☐Codeine ☐Penicillin
☐Erythromycin ☐Tetracycline ☐Latex
☐Dental Anesthetics ☐Metals ☐Other
Please list OTHER DRUG ALLERGIES:_____
_____
MEDICATIONS you are taking: _____
_____
_____