Wright Family Dentistry

PATIENT INFORMATION (THE PERSON SEEING THE DENTIST):

Name_____**S.S.N.**_____
LAST FIRST M.I.

Address_____**City**_____**State**_____**Zip**_____

Home # (_____) _____**Cell #** (_____) _____**Work #** (_____) _____**Birthdate**_____

Employer_____ **Male** **Female** **Marital Status** **Single** **Married** **Divorced** **Widowed**

Spouse Name_____ **Spouse Employer**_____

Do you have DENTAL Insurance? Y or N **If yes, please present your card to the receptionist.**

EMAIL_____
Who referred you to our practice?_____
General dentist?(if here for ortho only)_____
Is the patient a fulltime student? Y or N
Physician's Name and phone#
_____
Emergency Contact (SOMEONE NOT LIVING WITH YOU)_____
Phone (____) _____
Relationship to patient_____
IF PATIENT IS A DEPENDENT:
Mother/Guardian's name:_____
Phone number:_____
Driver License #_____
Father/Guardian's name:_____
Phone number:_____
Driver's License #_____

Race (circle one): white / Black or African American / Asian American Indian or Alaska Native
Native Hawaiian or other Pacific Islander / Other / Decline
Ethnicity (circle one): Hispanic or Latino
Not Hispanic or Latino
Please list your preferred language: _____

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy that may be indicated in connection with the dental care of the patient above listed, and further authorize and consent that the doctor chooses and employs such assistance as he deems fit. I also understand that prior to treatment, the doctor and/or his staff will give full explanation of the procedure(s). I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my dependent or me to third party payers and/or health practitioners. I agree to pay for all services rendered on my or my dependents behalf, including all expenses incurred for delinquent accounts.

SIGNATURE_____

PRINT NAME_____

RELATIONSHIP_____DATE_____

OFFICE POLICY

Welcome to the office of Wright Family Dentistry. To run in an efficient manner, we must set forth an office policy. As follows is a summary of our office policy. We ask that you please read and sign below.

Payment is due at time of service. We do not accept any type of payment plan except for orthodontics.

We will file insurance as a courtesy to you. We can only estimate what your insurance might pay. You will be responsible for any amount insurance doesn't pay.

Broken appointments will not be accepted. We ask that you please give at least 48 hour notice if you will not be able to come in for an appointment. Our office attempts to call you the day in advance to confirm appointments. Please call our office to confirm if we have not reached you. Your appointment may be cancelled if we are not able to reach you to confirm. A fee of $25 may be applied to your account for no show appointments or you may be dismissed as a patient.

I have read and understand the policy set forth by this office. I understand that I am financially responsible to Damon C. Wright, D.D.S for the charges incurred due to services rendered and so herein promise payment for those charges. I further acknowledge and agree that if collection is made by suit or otherwise, I am responsible for all collection cost, including attorney fees.

Signature_____

CONSENT

To deliver the best and safest possible care to you, it is essential that we are able to access your medical history from other providers. A complete history of medical conditions, allergies, prescriptions and any other necessary medical information will allow us to safely and effectively carry out any necessary therapies or treatments.

I give Dr. Damon C Wright and Wright Family Dentistry authorization to access my medical history from doctors, therapist, and pharmacists that have provided me treatment, therapies, or prescriptions.

Signature_____

WRIGHT FAMILY DENTISTRY, DAMON C. WRIGHT, D.D.S

HEALTH PROBLEMS AND MEDICATIONS:Please list all current medications AND what condition they are used to treat:

_____

_____

_____

_____

PREFERRED PHARMACY AND LOCATION _____

ALLERGIES: Please list all medication allergies AND food allergies: What reaction do they cause?

_____

_____

_____

_____

_____

_____

HEALTH HISTORY					
ABNORMAL BLEEDING OR BRUISING	Y	N	JOINT REPLACEMENT OR IMPLANT	Y	N
ACID REFLUX	Y	N	KIDNEY DISEASE	Y	N
ADHD	Y	N	LIVER DISEASE	Y	N
AIDS OR HIV (CIRCLE WHICH ONE)	Y	N	MS	Y	N
ANEMIA	Y	N	MUSCULAR DISTROPHY	Y	N
ARTHRITIS	Y	N	ORGAN TRANSPLANT	Y	N
ASTHMA	Y	N	OSTEOPOROSIS	Y	N
AUTISM	Y	N	PARKINSONS	Y	N
BIPOLAR	Y	N	SEIZURES	Y	N
BLOOD CLOTS	Y	N	SEXUALLY TRANSMITTED DISEASE	Y	N
CANCER (LIST TYPE)	Y	N	SLEEP APNEA	Y	N
CARDIAC PACECMAKER	Y	N	SPINA BIFIDA	Y	N
COPD	Y	N	STOMACH TROUBLES/ ULCERS	Y	N
CYSTIC FIBROSIS	Y	N	STROKE (LIST DATE)	Y	N
DEPRESSION	Y	N	RECENT WEIGHT LOSS	Y	N
DIABETES	Y	N	RESPIRATORY PROBLEMS (LIST TYPE)	Y	N
EMPHYSEMA	Y	N	THYROID PROBLEM	Y	N
HEART ATTACK (LIST DATE)	Y	N	TMJ	Y	N
HEART DISEASE (LIST TYPE)	Y	N	TUBERCULOSIS	Y	N
HEART MURMUR OR MVP	Y	N	USE RECREATIONAL DRUGS	Y	N
HEPATITIS (LIST TYPE)	Y	N	PREGNANT & DUE DATE	Y	N
HIGH BLOOD PRESSURE	Y	N	OTHER		
HODGKINS DISEASE	Y	N			

SMOKING STATUS (CIRCLE ONE):

NEVER SMOKED FORMER SMOKER CURRENT SMOKER

FORMER SMOKER & SMOKELESS TOBACCO USER

CURRENT SMOKER & SMOKELESS TOBACCO USER

CURRENT SMOKELESS TOBACCO USER FORMER SMOKELESS TOBACCO USER

Patient Signature_____ Date_____

Wright Family Dentistry

PRIVACY NOTICE ACKNOWLEDGEMENT

The signature below acknowledges a copy of this Notice was RECEIVED (not necessarily read).

_____ _____ _____

Date Patient/Legal Representative Signature State Capacity, if Legal Representative

_ _

For internal use only: Lack of Patient Acknowledgement:

Date: Reason Staff Signature

GENERAL INFORMED CONSENT

My dental office philosophy is based upon my commitment to preventative dentistry, to quality restorative dentistry, and to creating a supportive and nurturing environment for the children and adults under my dental care. My office staff and I are dedicated to providing safe, comfortable and appropriate dental treatment for all our patients.

For your child's safety, parents and other caretakers are required to remain in the reception area during the child's dental appointment. If your child has special needs that would require your presence during treatment, please inform the receptionist.

It is necessary for me to obtain your INFORMED CONSENT before I can provide any dental services for you or your child. Our general office policy is to "inform before we perform". Specifically, I am requesting your permission for the following diagnostic and preventative dental procedures: comprehensive clinical examination, selected diagnostic x-rays when indicated, a thorough cleaning, a fluoride treatment, sealants and selected medicated temporary fillings if indicated.

In addition, if other dental treatment is necessary, I will require your consent for the procedures including, but not limited to the following: local anesthesia and extensive use of the classic "show and tell" method of introducing new methods, instruments, and materials to you or your child. A specific treatment plan for future appointments will be discussed.

Having read the above and understanding it, I hereby give my consent to Damon C. Wright, D.D.S., to provide mutually agreed upon dental service for my child or me. I further agree that this consent shall remain in full force unless withdrawn in writing by the person who has signed below on behalf of the minor patient indicated below, or the adult indicated below.

As with all medical treatments, the fee collected is for the therapy, not for a guarantee of success. Additional treatment may be required and can be completed at normal fees.

_____ _____ _____

Date Patient Signature/ Legal Representative if Legal Representative, explain the capacity

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Patient's Name_____ DOB: _____ SSN: _____

Below is a list of person's that you give permission for our clinic to discuss and use the patient's protected health information, including conditions and treatment plans, prescriptions and x-rays, and to obtain consent for treatment from listed persons:

NAME	RELATIONSHIP TO YOU	TELEPHONE #

I understand that it is my responsibility to update this list in order to keep accurate those authorized persons to receive or use this patient's healthcare information.

_____ _____ _____

Date Patient Signature/ Legal Representative If Legal Representative, explain the capacity

ASSIGNMENT OF BENEFITS AND RELEASE OF RELATED MEDICAL RECORDS

Patient _____ SSN _____

We will be happy to verify your insurance eligibility and benefits, however, insurance company's give only an estimate of what percentages may be paid, they will not guarantee benefits over the phone. If eligibility can be confirmed, you will be allowed to pay your estimated portion at the time of visit. As a courtesy to you, this office will file insurance.

I have reviewed the insurance information and I agree to be responsible for all charges for dental services and materials not paid to Wright Family Dentistry by my dental benefit plan. I hereby assign, transfer, and set over to Wright Family Dentistry all of my rights, title, and interest to my dental reimbursement benefits under my insurance policy. I authorize the release of any medical information to determine these benefits. This authorization shall remain valid until written notice is given by me revoking said authorization.

_____ _____ _____

Date Patient signature/ Legal Representative if Legal Representative, explain the capacity