Michael J. Whitted
DENTISTRY

All Sections MUST be completed. If not applicable, please indicate as N/A

Patient Information

Last Name_____________________________ First Name_________________________ MI______

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other________________

Birth Date _____/_____/______ Soc. Sec. #_____________________ DL#____________________

Address_______________________________________ City_______________ State_____ Zip________

Home Phone_____________________ Cell Phone___________________ Work Phone________________

Email_________________________

Emergency Contact

Name_______________________________ Phone______________________ Relationship_____________

Name_______________________________ Phone______________________ Relationship_____________

Insurance Information

☐ Policy Holder information is the same as patient information

Last Name_____________________________ First Name_________________________ MI______

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other________________

Birth Date _____/_____/______ Soc. Sec. #_____________________ DL#____________________

Address_______________________________________ City_______________ State_____ Zip________

Home Phone_____________________ Cell Phone___________________ Work Phone________________

Employer Name_____________________ Relationship to Insured ☐ Spouse ☐ Child ☐ Other_________

Insurance Company_________________ Phone Number___________________

ID#______________________ Group#_______________

Referral Information

Were you referred to us? If so, whom may we thank for referring you to our practice? (Remember: Both parties receive a $50 credit! Limit **ONE** per family. Not valid with any other coupons)

☐ Another Patient _______________ ☐ Website ☐ Drive By/Walk In

☐ Welcome Wagon ☐ Internet Search/Reviews ☐ Cash Coupon

☐ Insurance Company ☐ Direct Mailer ☐ Other _______________

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Patient Name____ Date of Birth_____________

Dental History

Are you in dental discomfort today?___________________________________
Former Dentist_________________________ Phone______________________
Date of last dental care______________ Date of last x-rays_________________

Check all that apply:

- ☐ Sensitivity when biting
- ☐ Sensitivity to cold/hot
- ☐ Sensitivity to sweets
- ☐ Loose teeth/broken fillings
- ☐ Bleeding gums
- ☐ Sores/growth in mouth
- ☐ Food collection between teeth
- ☐ Periodontal treatment
- ☐ Bad breath
- ☐ Sinus problems
- ☐ Clicking/popping jaw
- ☐ Grinding or clenching
- ☐ Snoring
- ☐ Jaw pain
- ☐ Sleep apnea
- ☐ C-PAP

How often do you brush?__________________________ Floss?__________________________
How do you feel about the appearance of your teeth?____
Ever experience an adverse reaction during or in conjunction with a dental procedure? _____________________
If yes, explain____
Other information about your dental health or previous treatment_______________________________________

Medical History

Physician's Name_______________________ Phone________________________ Date of last visit_____________
Have you ever had any serious illnesses or operations? Y N If yes, describe_______________________________
____
Have you ever been required to take antibiotics before a dental appointment?______________________________

Check whether you have, or have ever had any of the following:

- ☐ AIDS/HIV Positive
- ☐ Alcoholism
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Anxiousness
- ☐ Arthritis/ Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints (any type)
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bruise Easily
- ☐ Cancer or Tumors
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Congenital Heart Disease
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Dizzy Spells
- ☐ Drug Addiction
- ☐ Eating Disorder (any form)
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Heart Surgery
- ☐ Hemophilia/ Abnormal Bleeding
- ☐ Herpes/ Cold sores
- ☐ Hepatitis (any form)
- ☐ High Blood Pressure
- ☐ Kidney Troubles
- ☐ Liver Disease
- ☐ Material Allergies (Latex, Metal)
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problem
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Rapid Weight Gain/ Loss
- ☐ Respiratory Disease
- ☐ Rheumatic/ Scarlet Fever
- ☐ Seizure
- ☐ Shortness of Breath
- ☐ Spina Bifida
- ☐ Stroke
- ☐ Thyroid Disease (Hyper/Hypo)
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Ulcer/ Colitis
- ☐ Venereal Disease (STDs)

Women Only: Are you Pregnant? Y N Nursing? Y N Taking Birth Control Pills? Y N

Are you currently taking any medications? Yes No If yes please list all:
____
Do you have any Drug Allergies? Yes No List all: ____

I understand the above information is necessary and have answered all questions to the best of my knowledge.

Signature____ Date__________

Consent for Use and Disclosure of Health Information

HIPAA Privacy Form

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations such as quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice /clinic have the right to change its privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, it must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

I, ______________________________hereby authorize **Michael J. Whitted & Associates** to release my records and/or any information to:

*****____

Name/Relationship

*****____

Name/Relationship

*****____

Name/Relationship

Signature____ Date__________________

(*Patient, parent, or legal guardian)*

If signed by a patient representative, please state relationship to patient____________________

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill and keeping your scheduled appointment is considered part of your treatment program. Your clear understanding of the Financial Policy and Cancellation Policy is important to our Professional Relationship. Please talk to our office team if you have any questions.

Financial Policy

Full payment is due at time of service

Our office accepts assignment of insurance benefits. However, it is your responsibility to pay copays, deductibles, and any amount not expected from your insurance at the time treatment is provided, unless financial arrangements have been made. If you do not have insurance, or if our office does not accept assignment for your insurance company, then payment is due in full at time of treatment.

If your insurance company has not paid the balance in the full within **60 days**, the balance of your account will become your responsibility. Please be aware that some and perhaps all of the services provided may be non-covered services and not considered necessary under your dental insurance.

After 60 days a finance charge will be applied at a 1.5% per month charge (18% annually). In the event of default, the undersigned agrees to pay legal interest on the indebtedness, together with such collection costs and attorney fees as may be required to collect on this balance.

Please remember that insurance is a contract between you and your insurance company. Our office is not a part of this contract. You are responsible for the timely payment of your account and that having dental insurance coverage is not a guarantee of payment. Remember you are responsible for understanding your insurance in regards to what is covered, not covered, limitations, exceptions, waiting periods etc.

Our office accepts Cash, Check (with valid ID), Visa, Mastercard, Discover, and Care Credit

Rescheduling Policy

24 hour notice is required to make changes to a reserved week day appointment and **72-hour** notice for changes to a Saturday appointment. A charge will be assessed for appointments changed less than the 24 or 72 hour notice. Cancellation fee is subject to appointment length.

We believe that the dental appointment represents a shared responsibility for both the doctor and the patient in order to have quality dental care. These appointments must be kept and in the event you need to change a scheduled appointment; our office requires these notifications

I have read the above and fully understand the terms.

Signature____ Date_____________