

Whole Health Dentistry

Beautiful healthy smiles from our family to yours

Patient Information

Patient _____ Gender M F
Last First Middle Initial
Marital Status _____ Birth date ___ / ___ / ___ SS# ___ - ___ - ___ Drivers License # _____
Address _____ City _____ State _____ Zip _____
Home Phone (____) _____ Cell Phone (____) _____ Work Phone (____) _____
Employer _____ Occupation _____

Responsible for Payment Self Other _____ Relationship _____
Address (if other than yours) _____ City _____ State _____ Zip _____
Home Phone (____) _____ Work Phone (____) _____
SS# ___ - ___ - ___ Drivers License # _____

Emergency Contact Person _____ Relation _____ Phone _____

Who referred you to our office? _____ **E-mail:** _____

Insurance Information

Primary Dental Insurance Carrier _____ Phone _____
Claims Mailing Address _____
City _____ State _____ Zip _____
Subscriber Name _____ DOB _____
Group # _____ ID # _____
Employer _____ SS # _____

Secondary Dental Insurance Carrier _____ Phone _____
Claims Mailing Address _____
City _____ State _____ Zip _____
Subscriber Name _____ DOB _____
Group # _____ ID # _____
Employer _____ SS # _____

Authorization of Treatment and Assignment of Benefit

I authorize Whole Health Dentistry to treat me. I further authorize the release of medical information necessary for the completion of insurance forms. I authorize payment directly to Whole Health Dentistry for all dental, medical, or surgical benefits payable to me under the terms of my insurance. I understand that I am financially responsible for all charges not paid by my insurance. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Patient/Parent Legal Guardian

Date

Whole Health Dentistry

Name: _____

HEALTH HISTORY

Name _____ Age _____

How would you rate your general health? Excellent Good Fair Poor

Medical History Please check any that you have or have had in the past

- | | |
|---|--|
| <input type="checkbox"/> Rheumatic Fever or Rheumatic Heart Disease | <input type="checkbox"/> Artificial Heart Valve |
| <input type="checkbox"/> Heart Disease or Heart Attack | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Heart Murmur or Mitral Valve Prolapse | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Chest Pains or Angina |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> Hepatitis / Liver Disease | <input type="checkbox"/> Tuberculosis (TB) |
| <input type="checkbox"/> Thyroid Trouble | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Diabetes (sugar) | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> HIV or other immunosuppressive disease | <input type="checkbox"/> Radiation or other cancer therapy |
| <input type="checkbox"/> Pregnancy - Expected due date: _____ | |

Doctor Comments: _____

Do you have or have you had any disease or condition not listed here? Yes No
If yes, please describe _____

Have you ever been hospitalized? Yes No
If yes, please explain? _____

Have you had an allergic reaction to any drugs or medication? Yes No
If yes, Please list _____

Name of current physician _____
City _____ State _____ Zip _____ Phone(____) _____

Please list all drugs or medications you are currently taking

Drug Name	Reason for taking
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____

I have reviewed the information provided and to the best of my knowledge it is complete and accurate.

Whole Health Dentistry

Name: _____

TMJ Screening History

Please check any that you have or have had in the past

- _____ Have you ever had a problem with jaw joints? (Your TMJ?)
- _____ Have you ever been injured by a blow to the jaw?
- _____ Do you ever have any click, pops, or grating sounds in your jaw joints?
- _____ Do you have difficulty chewing gum?
- _____ Do you have difficulty eating bagels or chewy foods?
- _____ Do you have trouble sleeping?
- _____ Do you have difficulty keeping your mouth open wide during a cleaning appointment?
- _____ Do you have frequent headaches? If so, how often and where?
- _____ Has your jaw ever locked open or closed?
- _____ Have you ever been treated for a TMJ problem?

Whole Health Dentistry

Name: _____

Composite Filling Consent Form

Dr. Warnock believes in providing the best and the safest possible treatment. Thanks to advances in modern dental materials and techniques, teeth can be restored with a very aesthetic and natural appearance. That is why at Whole Health Dentistry, we only restore teeth with composite (tooth colored) filling. Although we use the finest, most modern materials available, some insurance companies only have allowance for amalgam (mercury) fillings on back teeth. In placing these fillings there may be a difference in cost but we promise the value is there. We believe that it is not only our responsibility to educate our patients regarding treatment, but also to make them fully aware of any additional expenses that may arise due to treatment the Doctor deems necessary.

I do fully understand that my insurance company may only extend benefits for an amalgam (mercury) filling, and I am prepared to pay the difference at the time of treatment.

Signature

Date

Treatment Consent Form

Yes, I hereby authorize Whole Health Dentistry to do the following which may include but not limited to:

- *Taking of X-Rays, tests, and photographs before, during, and after treatment
- *Medication to control pain during dental treatment
- *Prescribing medications following treatment
- *Request parents and siblings of minor children being treated to remain in reception area during dental treatment
Unless asked otherwise
- *Share my information with other doctors and staff when a team approach is necessary or for the use in scientific Papers or demonstrations.

Yes, I understand that Whole Health Dentistry will inform me of any dental needs or further treatment resulting from my exam, any risks involved in the treatment, and the possible consequences of not completing the prescribed services.

Yes, I understand that whole Health Dentistry cannot make promises concerting the results of, or my satisfaction with treatment or services.

Yes, I understand that I am responsible for paying, in full, at the time services are rendered.

Signature

Date

Notice of Privacy Practices

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

We have the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes.

Signature

Date