MEDICAL HISTORY

Name: _____ ( ) M ( ) F Date of Birth: _____
Address: _____City, State, Zip:_____
Contact: Home Phone _____ Cell Phone _____ Work Phone _____
What is your estimate of your current health? Poor _____ Fair _____ Good_____

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO		YES	NO
Hospitalization for illness or injury…….	☐	☐	Stomach or duodenal ulcer……	☐	☐
Allergic reaction to:			Autoimmune disease…….	☐	☐
• Aspirin, Ibuprofen……	☐	☐	Arthritis…….	☐	☐
• Penicillin……...	☐	☐	Contact lenses……	☐	☐
• Sulfa……..	☐	☐	Head or neck injury……...	☐	☐
• Codeine…….	☐	☐	Epilepsy, convulsions (seizures)....	☐	☐
• Sedative…….	☐	☐	Viral infections or cold sores…….	☐	☐
• Local Anesthetics……	☐	☐	Lumps or swelling in the mouth…	☐	☐
• Latex…….	☐	☐	Hives, skin rash, hay fever……	☐	☐
• Metals……	☐	☐	Hepatitis (type ___).....	☐	☐
• Any other allergies……	☐	☐	HIV / AIDS……...	☐	☐
Heart problems…….	☐	☐	Tumor or abnormal growth……...	☐	☐
Heart murmur……...	☐	☐	Radiation therapy……..	☐	☐
Rheumatic fever……...	☐	☐	Chemotherapy……...	☐	☐
Blood pressure HIGH / LOW…….	☐	☐	Emotional problems……..	☐	☐
Pacemaker……	☐	☐	Psychiatric treatment…….	☐	☐
Stroke……..	☐	☐	Antidepressant treatment……...	☐	☐
Do you have artificial heart valve(s)?.....	☐	☐	Alcohol or drug dependency…….	☐	☐
Do you have artificial joint(s)?..... Date of placement_____	☐	☐	Taken steroids within the last 2 years……...	☐	☐
Has your MD told you need to take an antibiotic before Dental Treatment?.....	☐	☐	Ever taken Bisphosphonates (IV or Oral (Actonel, Bonica, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos)	☐	☐
Anemia or other blood disorders…….	☐	☐			
Prolonged bleeding due to slight cut……...	☐	☐	ARE YOU:		
Tuberculosis…….	☐	☐	Presently being treated for illness	☐	☐
Asthma/ Emphysema……...	☐	☐	Aware of a change in your health..	☐	☐
Sinus problems…….	☐	☐	Often exhausted or fatigued……..	☐	☐
Kidney disease…….	☐	☐	Subject to frequent headaches…..	☐	☐
Jaundice or Liver disease…….	☐	☐	A smoker-*How many per day?*___	☐	☐
Hormone deficiency…….	☐	☐	Using a CPAP?.....	☐	☐
HIgh cholesterol……...	☐	☐	Are you anxious about dentistry?..	☐	☐
Diabetes……...	☐	☐	FEMALE- use birth control pills...	☐	☐
Glaucoma…….	☐	☐	FEMALE- pregnant……...	☐	☐
			MALE- have prostate disorder…..	☐	☐

Please describe any current medical treatment, impending or recent surgery, or other treatment that may possibly affect your dental treatment._____

_____

List (or attach a separate list if extensive) any medications taken within the last two years.

_____

_____

UPDATE - PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY AND MEDICATIONS

SIGNATURE_____ **DATE**_____

Initial _____ **Date**_____ **Initial** _____ **Date**_____ **Initial** _____ **Date**_____

DENTAL HISTORY

Who can we thank for referring you to our office: _____

Previous Dentist _____ How long? _____

Last dental exam/ treatment _____ Last dental x-ray _____

How often do you have your teeth cleaned? 3 mo _____ 4 mo _____ 6 mo _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
1. Unhappy with the appearance of your teeth…….	☐	☐
2. Unfavorable dental experiences……...	☐	☐
3. Dental fears……..	☐	☐
4. Problems with effectiveness or bad reactions to dental anesthetic……..	☐	☐
5. Orthodontic treatment (braces) / when…….	☐	☐
6. Periodontal (gum) treatment / when…….	☐	☐
7. Bleeding gums……..	☐	☐
8. Do you avoid brushing any part of your mouth……	☐	☐
9. Part of your mouth sensitive to temperature…….	☐	☐
10. Sore teeth…….…….	☐	☐
11. A burning sensation in your mouth…….……	☐	☐
12. Difficulty swallowing…….…….	☐	☐
13. An unpleasant taste or odor in your mouth……...	☐	☐
14. Dry mouth…….……	☐	☐
15. Jaw problems (Temporomandibular joint)…….……...	☐	☐
16. Difficulty opening your mouth widely…….	☐	☐
17. Stiff neck muscles…….	☐	☐
18. Awaken with an awareness of your teeth or jaws…….……	☐	☐
19. Tension headaches……	☐	☐
20. Clench or grind your teeth……	☐	☐
21. Do you wear a night guard at night……..	☐	☐
22. Lost any teeth ……...	☐	☐
23. Do you sweat or tremble a lot during examination …….	☐	☐
24. Do unfamiliar people or places make you uncomfortable …….……..	☐	☐
25. Are you happy with the color of your teeth …….	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check yes or no)
☐	☐	Has your present denture been relined? When?_____
☐	☐	Is your present denture a problem? Describe_____
☐	☐	Satisfied with the appearance?_____
☐	☐	Satisfied with the comfort?_____
☐	☐	Satisfied with the chewing ability?_____
		When did you receive your first partial of complete denture?_____
		How long have you worn your present denture?_____

Patient's Signature_____ Date_____

Person Responsible for Payment

Name:_____
Last First Middle

Address:_____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address:_____

Marital Status (Circle): Single Married Separated Divorced Widowed

Sex (Circle): Male Female Birth Date:_____

Relationship to Patient (Circle): Self Spouse Child Other_____

Emergency Contact_____
Name Address Phone #

Insurance

Primary Dental Insurance: _____ Subscriber Name_____

ID #:_____ Birthdate:_____ Group #:_____ Employer:_____

Dental Insurance Mailing Address_____ Insurance Ph#_____

Secondary Dental Insurance:_____ Subscriber Name:_____

ID #:_____ Birthdate:_____ Group #:_____ Employer:_____

Dental Insurance Mailing Address_____ Insurance Ph#_____

I authorize the release of any medical or other information necessary to process my claims as well as payment of dental benefits to Dr. Wadhwani for services rendered. This authorization shall remain valid until such time as I request otherwise.

Office Financial Policy

I understand that payment in full is expected at the time of service for all appointments. Payment can be made by cash, check, or major credit card. Because we are a specialty office, many of our procedures fall into the category of elective dentistry and are not covered by insurance. We accept all PPO insurance plans, but are not contracted directly with any insurance company and are considered and out-of-network provider. All other insurance claims (including medical and accident claims) are the responsibility of the patient. Accounts over 30 days will accrue a monthly service charge of 1%. Unresolved accounts over 90 days due will be sent to a collection agency, interest and fees will be included.

Please sign below to acknowledge that you have read and agree to the above policy.

Signature_____Date_____

Notice of Privacy Practices – Acknowledgement

By my signature below, I acknowledge that I have read and understand the Notice of Privacy Practices of NW Prosthodontics. I understand that this information can and will be used to:

• Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
• Obtain payment from third-party payers for my health care services.
• Conduct normal health care operations such as quality assessment and improvement activities.
• Photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission.

_____ _____
Patient or legally authorized individual signature Date

_____ _____
Printed name if signed on behalf of the patient Relationship

For Office Use Only:
We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:
Circle one below:
The patient refused to sign,
Communication Barriers,
Emergency situation,
Other _____

Missed Appointment Policy

We require a **two-business day** advanced notice for any changes or cancellations of your appointments. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient who may have been waiting for this appointment time.

As a courtesy, we make every effort to remind patients of their appointments ahead of time; however, it is ultimately the patient's responsibility to keep their appointments.

- We reserve the right to charge a fee for late cancellations
- If you do not call within 2 business days or "no show" your appointment you will be assessed a $111 cancellation fee. This is NOT covered by your insurance but will be paid by you directly. Cancellation fees must be paid prior to the start of your next appointment.
- Excessive abuse of scheduled appointments may result in discharge from the practice.

By signing below, I acknowledge that I have read and agree to the above policy.

Signature_____ Date_____

WHAT IS THE BEST WAY TO CONFIRM YOUR APPOINTMENTS?

Home / Work / Cell / Email _____

Written Financial Policy

Thank you for choosing Chandur Wadhwani, DDS, MSD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check and All Major Credit Cards
  (We offer a 3% courtesy accounting adjustment to patients who pay for their treatment with **Cash or Check** at the beginning of care for treatment plans of $1000 or more.)

- We also offer in-house financing, with payments for services spread equally over 3 months with automatic credit card processing.

- Convenient Monthly Payment Options[1] from CareCredit or Lending Club Patient Financing*
  - Allows you to pay over time
  - Minimum transaction $1000.00
  - No annual fees or prepayment penalties

Please note:

Chandur Wadhwani, DDS, MSD requires payment in full prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For larger, more comprehensive treatment plans of $1000 or more, a 50% deposit is required to secure your initial treatment appointment.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide them with documentation they need to receive reimbursement for your treatment.

We charge 12% APR interest on all past due accounts. There is a $25 fee for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

*Subject to credit approval