

## PATIENT INFORMATION

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Sex: M F (Please circle)

Cell Phone Number: \_\_\_\_\_ Home Number: \_\_\_\_\_

\*Which number is your primary contact number? \_\_\_\_\_

Email Address: \_\_\_\_\_

Whom should we notify in case of emergency? \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

## PRIMARY DENTAL INSURANCE INFORMATION

Name of Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Policyholder Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Group#: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_

Are other dependents covered under this policy? Yes / No

If yes, please list: \_\_\_\_\_

Do you have secondary insurance coverage? Yes / No

If yes, please list: \_\_\_\_\_

## WRITTEN FINANCIAL POLICY

Thank you for choosing MW Dentistry and Esthetics. Our primary mission is to deliver the best and most comprehensive dental care possible. An important part of that mission is making the cost of care as easy and manageable by offering several payment options.

## PAYMENT OPTIONS

- Visa, Mastercard, American Express, Discover Card, cash or check
- We accept payment in thirds
- We offer a 5% courtesy discount to patients who pay with cash or check when treatment exceeds \$500 and is paid in-full at the initial appointment
- Convenient monthly payment plans through Care Credit

### Please note:

MW Dentistry and Esthetics requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

- For patients with dental insurance, we will bill your insurance as a courtesy to you. Although we may estimate what your insurance company may pay, it is your insurance company that makes the final determination of your eligibility. Not all services are covered by insurance. The patient will be responsible for the difference between insurance coverage and actual cost. If insurance does not cover the procedure, the patient will be responsible for the full amount. A pre-authorization can be made at the patient's request.
- A fee of \$25 is charged for patients who miss or cancel more than two times in a calendar year without 24-hour notice.
- There is a \$30 charge 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.

---

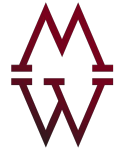
Patient Name (Please Print)

---

Patient, Parent or Guardian Signature

---

Date



## MEDICAL/DENTAL HISTORY

Name: \_\_\_\_\_ Physician: \_\_\_\_\_

Medical Health History: Although dental personnel primarily treat the areas in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. We thank you for answering the following questions as completely as possible.

Are you allergic to any of the following? (Circle if applicable)

Aspirin, Penicillin, Codeine, Acrylic, Metals, Latex, Local Anesthetics, other:

Do you have, or have you had, any of the following? (Circle if applicable)

AIDS/HIV Positive	Excessive Bleeding	Lung Disease
Alzheimer's Disease	Excessive Thirst	Mitral Valve Prolapse
Anaphylaxis	Fainting/Dizziness	Pain in Jaw Joints
Anemia	Frequent Cough	Parathyroid Disease
Angina	Frequent Diarrhea	Psychiatric Care
Arthritis/Gout	Frequent Headaches	Radiation Treatment
Artificial Heart Valve	Genital Herpes	Recent Weight Loss
Artificial Joint	Glaucoma	Renal Dialysis
Asthma	Hay Fever	Rheumatic Fever
Blood Disease	Heart Attack/Failure	Rheumatism
Blood Transfusion	Heart Murmur	Scarlet Fever
Breathing Problems	Heart Pacemaker	Shingles
Bruise Easily	Heart Trouble/Disease	Sickle Cell Disease
Cancer	Hemophilia	Sinus Trouble
Chemotherapy	Hepatitis A	Spina Bifida
Cold Sores	Hepatitis B or C	Stomach/Intestinal Disease
Congenital Heart Disorder	Herpes	Stroke
Convulsions	High Blood Pressure	Swelling of Limbs
Cortisone Medicine	Hives or Rash	Thyroid Disease
Diabetes	Hypoglycemia	Tonsillitis
Drug Addiction	Irregular Heartbeat	Tuberculosis
Easily Winded	Kidney Problem	Tumors/Growth
Emphysema	Leukemia	Ulcers
Epilepsy/Seizures	Liver Disease	Venereal Disease
	Low Blood Pressure	Yellow Jaundice

## MEDICAL/DENTAL HISTORY

Do you have any other condition not listed above? Yes / No

If yes, please explain: \_\_\_\_\_

Have you ever been hospitalized? Yes / No

Are you currently taking any prescription medications, over-the-counter medications, or vitamins/supplements? Yes / No

Please list name, dosage, and how often you take each medication: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

WOMEN: Are you pregnant or trying to become pregnant? Yes / No    Nursing? Yes / No

Are you taking birth control pills? Yes / No

## DENTAL HEALTH HISTORY

Please circle any of the following that apply to you:

Clicking/popping in jaw joint

Sensitivity in teeth

Pain in jaw joint

Food collection between teeth

Clenching/grinding

Canker sores

Bad breath

Fever blisters

Bleeding gums

Previous injury of mouth/jaws

Loose/broken teeth

Previous surgery in mouth

Have you ever had a reaction to local anesthetic? Yes / No

Have you ever had complications following dental treatment? Yes / No

Do you smoke or use tobacco products? Yes / No

Are you nervous/concerned about having dental work? Yes / No

Is there a specific treatment you are interested in having done? Yes / No

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or the patient's) health, and that it is my responsibility to inform MW Dentistry of any changes in medical status.

\_\_\_\_\_  
Signature of patient, parent, or guardian

\_\_\_\_\_  
Date

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the results of tests, procedures and financial information. Under HIPAA requirements, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental information, any diagnostic test results and/or financial information released to any family members, you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

**I authorize Dr. Molly Weindt of MW Dentistry and Esthetics to release my records and any information to the following individuals:**

1. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
2. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
3. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
4. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_
5. \_\_\_\_\_ Relation to Patient: \_\_\_\_\_

---

Patient Name (Please Print)

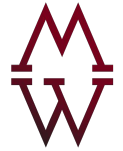
---

Patient Signature

---

Date

Patient Name: \_\_\_\_\_



DENTISTRY  
& ESTHETICS

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

### TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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

**Notice of Privacy Practices:** 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 other important matters about your protected health information, and accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve 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. These changes may apply to any of your protected health information that we maintain. You may obtain another copy of our Notice of Privacy Practices, including revisions, at any time by contacting:

**Privacy Officer:**  
Contact me to provide  
healthcare information

Telephone: 765-643-5356  
3221 Nichol Ave.  
Anderson, IN 46011

**Consent Does Not Expire after One Year.** By signing this Consent form, I am explicitly giving informed consent for the release of health records and health information for the purposes listed herein and that this Consent does not expire after one year for 1) the release of health records to a provider who is being advised or consulted with in connection with the releasing provider's current treatment of myself; or, 2) the maintenance organization, or third-party administrator for purpose of payment of claims, fraud investigation, or quality of care review and studies.

**Right to Revoke:** You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this Consent. You may obtain a revocation of consent form upon request.

### FOR TELEPHONE, TEXT, EMAIL COMMUNICATIONS

**I consent to the following:** This Dental Practice or its service provider may contact me to provide health care information such as appointment reminders, about treatment, payment, my insurance, my account, using prerecorded or artificial prerecorded voice or telephone equipment that may be capable of automatic dialing. This Dental Practice may call me, text me, or email me.

### SIGNATURE

I have received a copy of this practice's Notice of Privacy Practices and have had the full opportunity to read and consider the contents of this Consent form. I understand that by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

### Personal Representative

**Name:** \_\_\_\_\_

NOTE: A parent is considered a Personal Representative for a minor under the HIPAA Privacy Regulations.

**Relationship to Patient:** \_\_\_\_\_