DENTISTRY
& ESTHETICS

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: _____

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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

3221 Nichol Avenue, Anderson, IN 46011 | (765) 643-5356 | Fax (765) 643-0081
http://www.mwdentistry.com

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

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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: _____

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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

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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 Weiandt 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

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Patient Name: _____

DENTISTRY
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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:	Telephone: 765-643-5356
Contact me to provide	3221 Nichol Ave.
healthcare information	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: _____