

# WINDERMERE FAMILY DENTISTRY PATIENT REGISTRATION

Name: \_\_\_\_\_ Spouse: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Email address: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_  Male  Female  
Immediate family members? \_\_\_\_\_  
Please check your preference for appointment reminders.  Email  Text  Phone

## RESPONSIBLE PARTY (IF DIFFERENT FROM ABOVE)

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Home address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

## DENTAL INSURANCE INFORMATION

### PRIMARY INSURANCE

Policy holder's name: \_\_\_\_\_  
SS# \_\_\_\_\_ Employer: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Name of Ins. Co.: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Ins. mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ins. Phone # \_\_\_\_\_

### SECONDARY INSURANCE

Policy holder's name: \_\_\_\_\_  
SS# \_\_\_\_\_ Employer: \_\_\_\_\_  
Date of birth: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Name of Ins. Co.: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Ins. mailing address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Ins. phone # \_\_\_\_\_

### REFERRAL INFORMATION

Whom may we thank for referring you to our office: \_\_\_\_\_  
When was your last dental check-up? \_\_\_\_\_  
When was your last medical check-up? \_\_\_\_\_  
Who is your medical doctor? \_\_\_\_\_ Phone # \_\_\_\_\_

## PAYMENT / CANCELLATION POLICIES

Please help us keep the office running smoothly and efficiently. We make every effort to stay on schedule for your benefit and convenience. In return, we respectfully ask patients to fulfill scheduled appointments and be prompt.

Our standard office policy regarding appointments is as follows:

As a courtesy, we attempt to remind patients by telephone three business days prior to an appointment and by text and email 2 days before an appointment. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies you are obligated to be present. That time has been reserved especially for you.

If you need to change your appointment, please contact the office at least 2 business days prior to the appointment scheduled. This will alleviate any late charge that will normally incur.

We understand there are certain circumstances that prohibit you from doing this. Exceptions to this rule can be determined on an individual basis according to circumstances.

## INSURANCE POLICY

Thank you for taking the time to educate yourself on your particular insurance plan benefits. It is important that you understand your benefits and our office policy.

Dental insurance companies do not intend for their plans to cover all expenses. Their plans serve only as an aid toward acquiring better care.

The amount your plan pays is determined by how much you or your employer paid for the plan. The less that is paid for the insurance, the less you benefit. Insurance benefits packages vary from company to company, and we will gladly assist you with your insurance carrier before treatment.

Please understand that NOT ALL procedures are covered benefit in your plan. We will make every effort to know what your plan covers prior to the beginning treatment but ultimately it is your responsibility to know what is covered under your plan.

We require your application deductible plus your out-of-pocket costs at the time of service.

Some insurance companies tell their clients that "fees are above the usual and customary fees" rather than saying that "their insurance benefits are too low." In our office we do not view our patients as "usual and customary," but as quality people who expect quality dentistry. Remember, your insurance benefit is limited by what your employer pays for the plan less the profits of the insurance company.

## BILLING POLICY

We process all patient accounts through First Pacific Corporation, which states the following explanation of late and finance charges. Late Charge: If your minimum payment is not received by the due date you may be assessed a late payment charge. The amount of the late payment charge to be assessed is the maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be \$5.00 or 5% of the past due minimum payment, whichever is greater with a maximum of \$20.00. Finance Charge: The periodic finance rate is 1.25% monthly with a minimum of \$1.00 being imposed.

**I have read, understand and agree to the above office policies. I understand that I am fully responsible for all fees of the services rendered, regardless of insurance coverage.**

**I understand that my estimated out-of-pocket costs and deductible is due at the time of service.**

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

\_\_\_\_\_  
*Signature of Patient / Account Holder, Parent or Legal Guardian*

# PATIENT MEDICAL QUESTIONNAIRE

How is your general health?    Excellent    Good    Fair    Poor

Do you have, or have you had, the following?

- |                              |                             |                       |                              |                             |                            |
|------------------------------|-----------------------------|-----------------------|------------------------------|-----------------------------|----------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Stroke                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | High Blood Pressure   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Epilepsy                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Low Blood Pressure    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Venereal Disease           |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Joint Replacement     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Positive HIV / AIDS        |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bleeding Problems     | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Hepatitis                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Heart Attack          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Fainting                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Rheumatic Fever       | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Ulcers                     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mitral Valve Prolapse | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Psychiatric Treatment      |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cancer                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sinus Problems / Allergies |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Radiation Treatment   | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Thyroid Disease            |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Asthma / Emphysema    | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Diabetes                   |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Tuberculosis          | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Arthritis                  |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Liver Disease         | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Kidney Disease             |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Anemia                | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Bisphosphonate Therapy     |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cochlear Implant      | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Sleeping Disorder          |

Are you allergic to any drug, medicine, or supplement?    Yes    No

Explain: \_\_\_\_\_

Have you ever been hospitalized?    Yes    No

Explain: \_\_\_\_\_

Have you had surgery in the past five years?    Yes    No

Explain: \_\_\_\_\_

Are you under the care of a physician now?    Yes    No

Explain: \_\_\_\_\_

Are you taking medication, drugs or vitamins?    Yes    No

Explain: \_\_\_\_\_

Do you have any disease or problems not listed above?    Yes    No

Explain: \_\_\_\_\_

Do you use tobacco products?    Yes    No   If yes, what kind? \_\_\_\_\_

Do you wear contact lenses?    Yes    No

## WOMEN

Are you pregnant?    Yes    No   Delivery date: \_\_\_\_\_

Are you taking birth control pills?

## PATIENT DENTAL QUESTIONNAIRE

Is any part of your mouth sensitive to temperature or pressure?    Yes    No

Do your gums bleed when you brush or floss?    Yes    No

Have you ever been told that you have a gum problem?    Yes    No

Have you ever been treated for gum disease?    Yes    No

Have you ever had orthodontic treatment? (Braces)    Yes    No

Have you ever had an injury to your teeth?    Yes    No

Explain: \_\_\_\_\_

Have you ever had any injuries to your face or jaw / jaw joints?    Yes    No

Explain: \_\_\_\_\_

## PATIENT MEDICAL QUESTIONNAIRE CONTINUED

- Have you lost any teeth?  Yes  No  
If so, why? \_\_\_\_\_
- Does food catch between your teeth?  Yes  No
- Are you dissatisfied with the color of your teeth and their appearance?  Yes  No
- Is there anything you would like to change about the way your teeth look or feel?  Yes  No
- Do you clench or grind your teeth during the day?  Yes  No
- Have you been made aware of clenching or grinding your teeth at night?  Yes  No
- Do you have chronic headaches, neck or shoulder pain?  Yes  No
- Do you now, or have you ever had, pain in your jaw joints or the side of your face?  Yes  No
- Have you ever had a click, pop, or other noise in your jaw joint?  Yes  No
- Have you ever been unable to move your jaw or open your mouth widely?  Yes  No
- Do you snore?  Yes  No
- Have you been diagnosed with sleep apnea?  Yes  No

### DENTURE PATIENTS

- How long have you worn dentures? \_\_\_\_\_
- Why were your teeth extracted? \_\_\_\_\_
- How did you feel about getting dentures? \_\_\_\_\_

If you are currently having a denture problem, is it due to:  Pain  Discomfort  Appearance  Function

### EVERYONE

- Do you have any other dental concerns? \_\_\_\_\_
- Do you have any dental needs that should be addressed today? \_\_\_\_\_

### CONSENT

I certify that all the above information is correct and I am responsible for all medical information and will bring any changes to the attention of this office. I consent to treatment as necessary or desirable to the care of the patient named above, for the diagnosis of dental disease, deformity, or treatment of dental emergency. I consent to procedures deemed necessary by the doctor, understanding that the procedures will be explained in advance.

### FINANCIAL AGREEMENT

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor / child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand I am responsible for all collection costs, court costs & responsible for attorney fees. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all changes.

### I HAVE READ AND UNDERSTAND AND AGREE TO THE ABOVE POLICY

\_\_\_\_\_  
Signature of Patient / Account Holder, Parent or Legal Guardian

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

## WINDERMERE FAMILY DENTISTRY SLEEP SCREENING QUESTIONNAIRE

This questionnaire was designed to provide important facts to best address how we may help your overall health if you suffer from sleep disordered breathing. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke.

Name: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

### PLEASE CHECK ANY OF THE FOLLOWING THAT MAY CONCERN YOU OR THAT YOU STRUGGLE WITH:

- |   |   |
|---|---|
| <input type="checkbox"/> Frequent heavy snoring                   | <input type="checkbox"/> I have been told that "I stop breathing" when sleeping |
| <input type="checkbox"/> Snoring that affects the sleep of others | <input type="checkbox"/> Feeling un-refreshed in the morning                    |
| <input type="checkbox"/> Sleep apnea                              | <input type="checkbox"/> Morning hoarseness                                     |
| <input type="checkbox"/> CPAP intolerance                         | <input type="checkbox"/> Morning headaches                                      |
| <input type="checkbox"/> Significant daytime drowsiness           | <input type="checkbox"/> Nocturnal teeth grinding                               |
| <input type="checkbox"/> Difficulty falling asleep                | <input type="checkbox"/> Jaw pain   |
| <input type="checkbox"/> Gasping when waking up                   | <input type="checkbox"/> Facial pain  |
| <input type="checkbox"/> Nighttime choking spells                 | <input type="checkbox"/> Jaw clicking   |
| <input type="checkbox"/> Swelling in ankles or feet               | <input type="checkbox"/> High blood pressure                                    |

Would you be interested in a consult for Invisalign style braces?  Yes  No

Other: \_\_\_\_\_

## EPWORTH SLEEPINESS SCALE

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze

2 = I have a moderate chance of dozing

1 = I have a slight chance of dozing

3 = I have a high chance of dozing

### SITUATION

### CHANCE OF DOZING

- |   |       |
|---|-------|
| 1. Sitting and reading  | _____ |
| 2. Watching TV  | _____ |
| 3. Sitting inactive in a public place (e.g. a theatre or a meeting) | _____ |
| 4. As a passenger in a car for an hour without a break              | _____ |
| 5. Lying down to rest in the afternoon when circumstances permit    | _____ |
| 6. Sitting and talking to someone                                   | _____ |
| 7. Sitting quietly after lunch without alcohol                      | _____ |
| 8. In a car while stopped for a few minutes in traffic              | _____ |

TOTAL SCORE \_\_\_\_\_

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

**I acknowledge that I have reviewed a copy of the Notice of Privacy Policies.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: (please print) \_\_\_\_\_

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It is not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.