WHEATON™
— DENTAL —

Patient Registration

Patient Name: _____ **Date of Birth:** ___/___/___

If minor, name of legal guardian: _____

Gender: _____ **Married:** [ ] Y [ ] N **SSN:** _____-____-_____

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

Email: _____

Preferred Contact Method: [ ] Home [ ] Cell [ ] Work [ ] Email

Address: _____

Address 2: _____

City: _____ **State:** _____ **Zip:** _____

How did you hear about us? (If someone referred you, please write down their name so we can thank them)

☐ WCOL / Zuko ☐ Social Media ☐ Other: _____

Insurance Policy 1

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber name: _____ **Date of Birth:** ___/___/___

Subscriber ID #: _____ **Group #:** _____

Subscriber Address: _____

Insurance Carrier: _____ **Phone:** _____

Insurance Policy 2

Relationship to Subscriber: [ ] Self [ ] Spouse [ ] Child

Subscriber name: _____ **Date of Birth:** ___/___/___

Subscriber ID #: _____ **Group #:** _____

Subscriber Address: _____

Insurance Carrier: _____ **Phone:** _____

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— DENTAL —

Financial Policy

- Our fees are based on what is usual and customary for our area. We will assist you with your benefit eligibility before treatment to help you estimate your costs and maximize your insurance. You as a patient are always responsible for any charges not covered by insurance.
- Estimated fees are valid for 3 months following the time treatment was presented. Treatment can change as dental needs change. You will be notified of these changes.
- We have partnered with Care Credit, a patient financing company, and are pleased to offer our patients several programs utilizing deferred interest and extended payment plans.
- The claims we submit to insurance companies indicate that you have assigned these benefits to Wheaton Dental. However, if you are paid by the insurance company instead of Wheaton Dental, you are then responsible for the total account balance in full.
- Insurance balances not paid within 60 days may be billed to you. Keep your walk out statements and follow up with your insurance carrier to ensure prompt payment.
- Returned checks will be subject to a $30 returned check fee to cover processing fees charged to our office.
- Balances 60 days or older will incur a 1.5% finance charge equally 18% per annum unless previous financial arrangements are satisfied. Delinquent accounts will be handled by a collection agency.
- Forms of accepted payment include cash, checks (under $500), debit cards, Mastercard, Visa, and Discover credit cards.

Signature of Patient/Responsible Party: _____

Date: _____ Witness Initials: _____

Wheaton Dental
2760 London-Groveport Rd.
Grove City, OH 43123
(614)957-0057

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 23rd, 2018 and will remain in effect until further notice.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, but not before July 23rd, 2018. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this notice in written form.

QUESTIONS AND COMMENTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may contact our office using information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ashley Gregory
Telephone: (614)957-0057
Fax: (380)666-0377
E-Mail: info@wheatondentalohio.com
Address: 2760 London-Groveport Rd
Grove City, OH 43123

Signature of Patient/Responsible Party: _____

Date: _____ Witness Initials: _____

Patient Name:

Patient Account Number:

Medical History

Please complete this form in its entirety so we may provide you with the best possible dental care. All information provided is confidential and secure.

Primary Care Physician's Name: _____ Phone: _____

Please provide a list of current medications you are taking that are either prescribed or over-the-counter :

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Bonica, or other similar drugs? Yes ___ No ___

Please indicate if you have experienced allergic reactions or adverse effects from the following :

Aspirin	Yes ___ No ___	Iodine	Yes ___ No ___
Amoxicillin and/or Penicillin	Yes ___ No ___	Latex	Yes ___ No ___
Other antibiotics	Yes ___ No ___	Local anesthetics (ex. Novocaine)	Yes ___ No ___
Codeine	Yes ___ No ___	Metals	Yes ___ No ___
Ibuprofen	Yes ___ No ___	Sulfa drugs / Sulfites / Sulfides	Yes ___ No ___
Other: (Please specify): _____		Other: _____	

Please indicate which of the following you have had or presently have:

Heart attack or surgery	Y / N	Liver problems	Y / N	Hepatitis A, B, or C	Y / N
Chest pain	Y / N	Ulcers	Y / N	Venereal disease	Y / N
Congenital heart disease	Y / N	Diabetes Type I or Type II	Y / N	AIDS / HIV positive	Y / N
Heart murmur	Y / N	Thyroid problems	Y / N	Cold sores / fever blisters	Y / N
High and/or low blood pressure	Y / N	Glaucoma	Y / N	Blood transfusion	Y / N
Mitral valve prolapse	Y / N	Contact lenses	Y / N	Hemophilia	Y / N
Artificial heart valve/pacemaker	Y / N	Emphysema	Y / N	Sickle cell disease	Y / N
Rheumatic fever	Y / N	Chronic cough	Y / N	High cholesterol	Y / N
Arthritis / Rheumatism	Y / N	Tuberculosis	Y / N	Neurological disorders	Y / N
Cortisone medicine	Y / N	Asthma	Y / N	Epilepsy or seizures	Y / N
Swollen ankles	Y / N	Hay fever / allergy / hives	Y / N	Fainting or dizzy spells	Y / N
Stroke	Y / N	Sinus trouble	Y / N	Anxiety	Y / N
Diet (special / restricted)	Y / N	Radiation therapy	Y / N	Depression	Y / N
Artificial joints	Y / N	Chemotherapy	Y / N	Psychiatric / psychological care	Y / N
Kidney problems	Y / N	Tumors	Y / N	Chronic migraines / headaches	Y / N

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature _____ Date _____

Patient Name:

Account Number:

Dental History

Please complete this form in its entirety so we may provide you with the best possible dental care. All information provided is confidential and secure.

What is the reason for your visit today? _____

When was the date of your last dental visit? _____ What was your last visit in relation to? _____

How often do you visit the dentist? _____ How often do you brush your teeth? _____ How often do you floss? _____

What other dental aids do you use (Waterpik, Interplak, etc.)? _____

Do you currently have any dental concerns? Yes ___ No ___ If yes, please describe: _____

_____

Are any of your teeth sensitive to :

Hot or cold? Yes ___ No ___

Sweets? Yes ___ No ___

Biting and/or chewing? Yes ___ No ___

Do you:

Clench or grind your teeth? Yes ___ No ___

Bite your lips or cheeks regularly? Yes ___ No ___

Hold foreign objects with your teeth (pencils, pipe, pens, fingernails, etc.)? Yes ___ No ___

Breathe through your mouth? Yes ___ No ___

Have sore jaw bones, especially in the morning? Yes ___ No ___

Snore or have any other sleeping disorder(s)? Yes ___ No ___

Use tobacco products? Yes ___ No ___

Have you ever experienced:

Clicking or popping of the jaw? Yes ___ No ___

Joint, ear, or side of the face pain? Yes ___ No ___

Difficulty in opening or closing the mouth? Yes ___ No ___

Difficulty in chewing? Yes ___ No ___

Have you ever had:

Orthodontic treatment? Yes ___ No ___

Oral surgery? Yes ___ No ___

Periodontal treatment? Yes ___ No ___

Your teeth or bite adjusted? Yes ___ No ___

A bite plate or mouth guard? Yes ___ No ___

A serious injury to the mouth or head? Yes ___ No ___

Are you nervous about dental treatment? Yes ___ No ___

Have you ever had a bad dental experience? Yes ___ No ___

Have you noticed any odors or bad taste? Yes ___ No ___

Do you frequently get cold sores, blisters, or any other oral lesions? Yes ___ No ___

Have your parents experienced gum disease? Yes ___ No ___

Have you noticed any loose or moving teeth or change in your bite? Yes ___ No ___

Does food get caught in between your teeth? Yes ___ No ___

Are you satisfied with your teeth's appearance? Yes ___ No ___

Have you ever been instructed to take a pre-medication prior to dental treatment? Yes ___ No ___

Circle what you value the most in regards to your oral health:
Function, Longevity, Cosmetic, Comfort

Is there anything else you would like to communicate to us regarding your dental treatment? Yes ___ No ___

If yes, please describe: _____

_____