

## PATIENT REGISTRATION

ID: \_\_\_\_\_

Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

Patient Is: ☐ Policy Holder ☐ Responsible Party

Preferred Name: \_\_\_\_\_

Responsible Party ( if someone other than the patient )

First Name: \_\_\_\_\_

Last Name: \_\_\_\_\_

Middle Initial: \_\_\_\_\_

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

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

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

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

☐ Responsible Party is also a Policy Holder for Patient☐ Primary Insurance Policy Holder☐ Secondary Insurance Policy Holder

### Patient Information

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

Address 2: \_\_\_\_\_

City: \_\_\_\_\_

State / Zip: \_\_\_\_\_

Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Ext: \_\_\_\_\_

Cellular: \_\_\_\_\_

Gender: ☐ Male ☐ Female ☐ UnknownMarital Status: ☐ Married ☐ Single☐ Divorced ☐ Separated☐ Widowed

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

Age: \_\_\_\_\_

Soc Sec: \_\_\_\_\_

Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_

☐ I would like to receive correspondences via e-mail.

### Section 2

Employment Status: ☐ Full Time☐ Part Time☐ RetiredStudent Status: ☐ Full Time☐ Part Time

Medicaid ID: \_\_\_\_\_

Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_

Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_

Pref. Hyg: \_\_\_\_\_

### Section 3

**\* Emergency Name / #**

### Primary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

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

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

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_

### Secondary Insurance Information

Name of Insured: \_\_\_\_\_

Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: \_\_\_\_\_

Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_

Ins. Company: \_\_\_\_\_

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

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

Address 2: \_\_\_\_\_

Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_

Rem. Deduct: \_\_\_\_\_



**Eaglesoft Medical History**

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

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

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

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use controlled substances?	<input type="radio"/> Yes <input type="radio"/> No	If yes	_____

Women: Are you...

☐ Pregnant/Trying to get pregnant?☐ Nursing?☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin☐ Penicillin☐ Codeine☐ Acrylic☐ Metal☐ Latex☐ Sulfa Drugs☐ Local AnestheticsOther? ☐

If yes

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

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach/Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problems	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?

☐ Yes ☐ No

If yes

Comments:

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 patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

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



Signature

Stephen J. Wessels, DMD, PA

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336/838-4119 telephone • 336/838-1746 fax  
wesselsstaff@wilkes.net

## LOCAL ANESTHETIC CONSENT FORM

THIS CONSENT FORM IS DESIGNED TO MAKE YOU AWARE OF THE RISKS INVOLVED WITH LOCAL ANESTHESIA. THE RISKS INCLUDE, BUT ARE NOT LIMITED TO:

- There are risks of anesthesia that may affect your body, such as dizziness, nausea, vomiting, accelerated heart rate, slow heart rate, or various types of allergic reactions, any or all of these may require additional medical management or hospitalization.
- Restricted mouth opening during recovery, sometimes related to muscle soreness at the site of the injection requiring physical therapy.
- Local anesthesia may cause prolonged numbness that in some patients may result in injury from biting or chewing an area such as (lip, cheek and/or tongue) that has received the local anesthesia.
- Injury to nerves that can result in pain, numbness, tingling, or other sensory disturbances to the chin, lip, cheek, gums or tongue. This may persist for several weeks, months, or rarely, be permanent.
- Local anesthesia is administered with a very small fine needle. In very rare instances these needles may break off and be lodged in soft tissue, especially when a patient moves while anesthesia is being given.

I HEREBY ACKNOWLEDGE THAT I HAVE READ THIS DOCUMENT, AND HAVE DISCUSSED ALL QUESTIONS OR CONCERNS THAT I MAY HAVE REGARDING LOCAL ANESTHESIA.

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Patient's Printed Name

Signature (Patient, Parent or Legal Guardian)

Date



**Office Financial Policy and Assignment of Benefits**

We would like our patients to be informed of our financial policy. We are committed to providing you with the most comprehensive dental care using only the highest quality materials and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate our ability to provide excellent service to you while minimizing our administrative costs.

**Payment is due at the time service is rendered.** Our practice accepts cash, personal checks, MasterCard, Visa, Discover and Care Credit as a form of payment. All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is an agreement between you, your employer, and the insurance company.

Our practice is not a party to that agreement. If payment from your insurance company is not received within 45 days from date of service, you will be expected to pay the balance in full. As a courtesy to you we will help you process all your insurance claims. In order for our practice to file your insurance claim, you must bring proof of insurance at each appointment. Although we are willing to complete insurance information forms and submit a claim on your behalf, we do not accept responsibility for the outcome of the transaction. Completing insurance forms is a courtesy we extend to you in an effort save you time and to facilitate payment to our practice from your insurance company. By having our practice process your insurance forms, it is important that you understand that this does not eliminate your financial obligation for your treatment. Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. The following provisions identify our policies governing insurance claims:

1. We cannot provide services on the assumption the charges will be paid by an insurance company. We diagnose and recommend treatment based on what is necessary and in the best interest for our patients to optimize their oral health. We can only estimate your expected benefit payment, not guarantee it. Should your plan pay less than expected, you are fully responsible for the balance.
2. We require you to pay the **estimated** co-payment, which is the amount not covered by your insurance company, at the time we provide service to you. The co-payment is only an estimate of charges and may be found to be insufficient after review by your insurance company.
3. Our fees are generally considered to fall within the acceptable range (UCR) by most insurance companies. Some insurance companies pay a fixed allowance for certain procedures, and others pay a percentage of the charge. The benefits available to you are dictated by the policy purchased for you by your employer.
4. Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. If your claim is denied, you will be responsible for paying the full amount at that time.
5. Insurance payments ordinarily are received within 30-45 days from the time of billing. If your insurance company has not made payment to our practice within 60 days, we will ask you to pay the entire balance at that time. You will be responsible for seeking reimbursement from your insurance company at that time.
6. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company requests to sort out any confusion or questions that may arise. We will cooperate fully with the regulations and requests of your insurance company. It is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company to our practice.
7. Please update our office coordinators regarding any changes to your dental insurance, so that your claim can be processed in a timely manner.
8. If your son or daughter is enrolled in college you must provide proof of enrollment to your insurance carrier. Otherwise claims will be held up indefinitely by your insurance carrier.

**Returned checks and balances older than 30 days will be subject to a \$1.00 billing fee and a finance charge at the rate of 1.5% per month.**

Please do not hesitate to ask if you have any questions regarding this financial agreement. We are committed to providing you with the ultimate experience in dental care.

**I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THIS ASSIGNMENT OF BENEFITS AGREEMENT.  
I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.**

Patient's Printed Name

Signature (Patient, Parent or Legal Guardian)

Date

## Referral Source

### How did you hear about our office?

- ☐ Facebook Ad
- ☐ I'm a former patient of Dr. Wessels
- ☐ Internet/Reviews Search
- ☐ Newspaper Insert
- ☐ Postcard in the mail
- ☐ Saw the office driving by
- ☐ Someone Referred me (who was it?) \_\_\_\_\_
- ☐ TV Commercial (30-60 seconds long)
- ☐ TV Infomercial (30+ minutes long)
- ☐ Website (requested an appointment through our website)
- ☐ Yellowpages/Phonebook



## HIPAA Privacy Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand this information can and will be use to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers (insurance companies).
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed that I may review the practice's *Notice of Privacy Practices* for a more complete description of uses and disclosures before signing this consent. I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction.

I understand that I may revoke this consent at any time by making a request in writing except for information that has already been used or disclosed.

**Please list below the names of individuals you allow access to your information along with their relationship to you.**

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Patient's Printed Name

Signature (Patient, Parent or Legal Guardian)

Date