WOLF RIVER DENTAL

PATIENT REGISTRATION

(Please Clearly Print All Information)

Today's Date _____

Patient's Name _____ Patient's Date of Birth _____
(Last Name) (First Name) (M.I.)

Patient's Address_____
(Street) (City) (State) (ZIP)

Home Phone _____ Work Phone_____ Patient's Social Security #_____

Patient's Employer_____

YES NO
[ ] [ ] Are you covered by Medical Assistance or Badger Care?
[ ] [ ] Are you covered by dental insurance?

Primary Insurance: Name of Insurance Company _____

Subscriber's Name _____ Subscriber's Employer_____

Subscriber's Date of Birth _____ Subscriber's Social Security #_____

Insurance ID Number _____ Group Number_____

Secondary Insurance: Name of Insurance Company _____

Subscriber's Name _____ Subscriber's Employer_____

Subscriber's Date of Birth _____ Subscriber's Social Security #_____

Insurance ID Number _____ Group Number_____

Person responsible for account payment _____ Their SS#_____

OFFICE POLICIES

(Please read carefully and sign below)

"I understand that the information which I have provided on both sides of this form is essential to determine my dental needs and to provide appropriate dental treatment. I understand that if any change occurs in my health, I am to report it to the dental office as soon as possible. I understand that it is my reponsibility to report ALL changes in medical history and medicaitons prior to treatment.

I understand that payment for treatment is expected at the time of treatment, unless other arrangements are made prior to the start of treatment. **Due to the high cost of multiple billings, a charge of $5.00 per month will be added to each unpaid bill after 30 days.**

I understand that Wolf River Dental has a privacy policy which is in compliance with the Health Insurance Privacy and Portability Act (HIPPA) and that a copy of that policy is available for my inspection.

I certify by my signature that all information provided by me on this form is current, complete, and accurate."

Patient, Parent or Guardian Signature _____ Date_____

I (DO / DO NOT) agree to allow the release of information, or discuss aspects of my health care, with my (SPOUSE / SIGNIFICANT OTHER), OR _____ Relationship_____

WOLF RIVER DENTAL
PATIENT MEDICAL HISTORY
(Please Clearly Print All Information)

Patient's Name _____ Sex:___ Female ___Male

Physician's Name (Family M.D.) _____ Date of Birth_____

Have You Ever Had Any of the Following? (Check "Yes" or "No")

YES	NO		YES	NO	
[ ]	[ ]	Mital Valve Prolapse	[ ]	[ ]	Sinus Problems
[ ]	[ ]	Artificial Heart Valve	[ ]	[ ]	Asthma or Emphysema
[ ]	[ ]	Joint Replacement Surgery (Hip, knee, shoulder)	[ ]	[ ]	Cancer, Tumors or Growths
[ ]	[ ]	Heart Attack or Stroke	[ ]	[ ]	Radiation Therapy or Chemotherapy
[ ]	[ ]	Heart Surgery (Including bypass, pacemaker, valves)	[ ]	[ ]	Epilepsy or Seizures
[ ]	[ ]	Heart Murmur	[ ]	[ ]	Athritis / Reumatism
[ ]	[ ]	Rheumatic Fever	[ ]	[ ]	Blood Transusions
[ ]	[ ]	High or Low Blood Pressure	[ ]	[ ]	Kidney Disease
[ ]	[ ]	Diabetes	[ ]	[ ]	Tuberculosis
[ ]	[ ]	Liver Disease, Hepatitis, Jaundice	[ ]	[ ]	Glaucoma
[ ]	[ ]	Thyroid Disease	[ ]	[ ]	Venereal Disease
[ ]	[ ]	Tobacco Use	[ ]	[ ]	Eating Disorder
[ ]	[ ]	Have you ever tested positive for AIDS or HIV?			
[ ]	[ ]	Do you take medications to control blood pressure, regulate heart rate, or thin blood?			
[ ]	[ ]	Do you have a history of alcoholism or narcotic use?			
[ ]	[ ]	Have you ever had excessive bleeding from a cut or tooth extraction?			
[ ]	[ ]	Females: Are you pregnant at this time? Delivery date:_____			
[ ]	[ ]	Are you being treated by a physician now? For?_____			

Please list all operations you have had and reasons for hospitalizations _____
_____

Please check any of the following which you are allergic to, or have reacted adversely to:

[ ] Penicillin [ ] Codeine [ ] Local Anesthetic (Lidocaine, Novocain, etc)
[ ] Erythromycin [ ] Nitrous Oxide [ ] Latex

Please list all medications, foods or other substances not listed above, to which you have an allergy or adverse reaction:
_____
_____

Please list all drugs or medications which you are taking on a regular basis (both prescription and non-prescription, including pain relievers, blood pressure medications, bloods thinners, birth control pills, and vitamin/mineral supplement(s):
_____
_____

Do you have any other medical condition, not listed above, that we should know about? _____
_____

Patient Signature: _____ Today's Date:_____
(Parent or guardian if under 18)

For Office Use Only: History Reviewed

Date:	_____	_____	_____	_____	_____	_____	_____
Patient Initials:	_____	_____	_____	_____	_____	_____	_____
Staff Initials:	_____	_____	_____	_____	_____	_____	_____

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we *may not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.
MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

_____ _____
Please ***print*** name of Patient Please ***sign*** for Patient / Guardian of Patient

_____ _____
Legal Representative / Guardian Relationship of Legal Representative / Guardian

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes spouses, step-parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

☐ Cell Phone Confirmation
☐ Home Phone Confirmation
☐ Work Phone Confirmation
☐ Text Message to my Cell Phone
☐ Email Confirmation
☐ **Any of the Above**

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only
As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment ____
I could not communicate with the patient ____
The patient refused to sign ____
The patient was unable to sign because ____
Other (please describe) ____

_____
Signature of Privacy Officer

WOLF RIVER DENTAL

Financial Policy

Thank you for choosing Wolf River Dental. We value the trust you have placed in us by allowing us to care for you!

Payment Options:

- Cash, Check, Visa, MasterCard, American Express or Discover Card
    - We offer a courtesy accounting adjustment for payment in full with cash or check on or before the day of service.

- Convenient Monthly Payment Options from CareCredit
    - Allows you to pay over time
    - No interest charges for up to one year
    - No annual fees or prepayment penalties

For patients with dental insurance: we are happy to work with your carrier to maximize your benefit and bill them directly for reimbursement. Your **estimated** co-payment is due at the time service is rendered and may be adjusted after the time of treatment depending on the final reconciliation of insurance payments. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

Returned checks and balances older than 90 days will be subject to collection fees and finance charges.

If you have any questions, please do not hesitate to ask. We are here to help you accomplish your oral health goals!

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

WOLF RIVER DENTAL

ASSIGNMENT OF BENEFITS AGREEMENT FOR WOLF RIVER DENTAL

Our practice will accept an assignment of benefits from your insurance company with the conditions listed below. It is important to understand, though, that the agreement regarding your dental benefits is between you, your employer, and your insurance company. The obligation you have with our practice is to pay for all treatment and services we provide to you, regardless of the amount that may or may not be reimbursed by your insurance company. The following provisions identify our policies governing insurance claims.

- 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.
- We require you to sign this agreement and/or any other necessary assignment documents that may be required by your insurance company. This instructs your insurance company to make payment directly to our practice.
- 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 copayment is only an **estimate** of charges and may be found to be insufficient after review by your insurance company.
- Insurance payments ordinarily are received within 30-60 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.
- Our practice does not guarantee that your insurance company will pay for treatment you receive from our practice. We perform routine insurance billing procedures upon verification of coverage. However, if your claim is denied, you will be responsible for paying the full amount at that time.
- 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.

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 WOLF RIVER DENTAL.

_____

Print Name of Patient or Responsible Party

_____

Signature of Patient or Responsible Party Date

WOLF RIVER DENTAL

X-Ray/Records Release Form

*Please complete and mail or email your previous dentist if you would like any records or x-rays transferred to our office.

Date:_____/_____/_____

Please send all current records, including bitewing x-rays taken within the last **24** months, full series or panoramic x-rays taken within the last 5 years, and any other pertinent dental records to:

Wolf River Dental
PO Box 270
Shawano, WI 54166

Phone: 715-526-3314
info@wolfriverdental.com

I have an appointment scheduled on: _____/_____/_____

_____ _____/_____/_____
Print Name Date of Birth

_____
Address

_____
City/State Zip

_____
Signature