



Patient Registration

Date: _____

Patient Name: _____ Preferred Name: _____ ☐ Male ☐ Female

Last

First

Preferred Name

Birth Date: _____ Age: _____ SSN: _____ Email: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Home () _____ Cell () _____ Text alerts: ☐ Yes ☐ No

How did you hear about us? _____

Emergency Contact: _____ Relationship: _____

Previous Dentist: _____ Last visit: _____ Last x-rays: _____

Responsible Party

Responsible Party _____ Relationship to patient _____

Last

First

Birth Date: _____ SSN: _____

Address (if different from patient) _____ Phone () _____

City _____ State _____ Zip _____

Primary Insurance Information

Name of insured: _____ Relationship to patient: _____

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Address: _____ City: _____ Zip: _____

Insurance Company: _____ Address: _____ City: _____ Zip: _____

Insurance Phone Number: _____

ID# _____ Group # _____

Secondary Insurance Information

Name of insured: _____ Relationship to patient: _____

Insured SSN: _____ Insured Birth Date: _____

Employer: _____ Address: _____ City: _____ Zip: _____

Insurance Company: _____ Address: _____ City: _____ Zip: _____

Insurance Phone Number: _____

ID# _____ Group # _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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? ☐ Yes ☐ No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐ Yes ☐ No _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐ Yes ☐ No _____

Are you on a special diet? ☐ Yes ☐ No

Do you use tobacco? ☐ Yes ☐ No

Do you use controlled substances? ☐ Yes ☐ No

Women: Are you _____

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you allergic to any of the following? _____

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

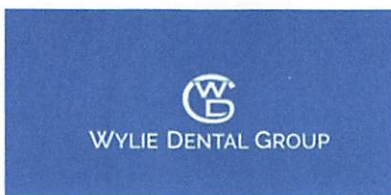
AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Renal Dialysis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

Have you ever had any serious illness not listed above? ☐ Yes ☐ No _____

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 _____



Notice of Privacy Practices Acknowledgement
Wylie Dental Group
161 Old Schoolhouse Lane
Mechanicsburg, PA 17055

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

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

I acknowledge that I have received your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the **Notice of Privacy Practices**.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to patient: _____

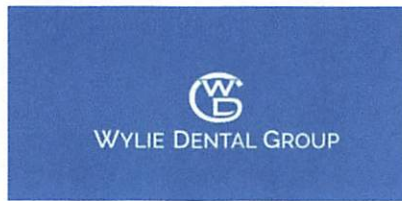
Signature Patient/Legal Guardian: _____

Date: _____

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this **Notice of Privacy Practices** acknowledgement, but was unable to do so as documented below:

Date: _____ Initials: _____ Reason: _____



Office and Financial Policy

At Wylie Dental Group, we are committed to providing our patients with the best possible care and service. It's important to us that you have a clear understanding of our office and financial policy.

Payment

Payment is due at the time service is rendered. We accept cash, check, most major credit cards and Care Credit. Non-insured patients over 65 will receive a 3% discount if using a credit card and a 5% discount if using cash or check when payment is made in full at time of service.

Insurance

Insurance benefits are determined by your employer. Insurance coverage is a contract that exists between you and your insurance company. Insurance coverage and benefits are your responsibility. Insurance is not a guarantee of payment, nor does it cover all costs involved with your treatment. As a courtesy, we will file your claim for you to your insurance company, if current and accurate information is provided. If we are unable to verify your coverage, you will be responsible for payment in full at time of service. Deductible and estimated co-payments are due at time of service. You are responsible for any portion of your bill not covered by your insurance. Should your insurance company determine that any service you received is "not covered", you are responsible for payment regardless of the original estimate of insurance benefit.

Delinquent Accounts

All accounts that are 90 days past due will be sent to collections and a 25% processing fee will be applied to your account. If your account is in collections, we will not schedule any appointments until your balance is paid in full. Payment can be made to our office or the collection agency. A billing fee of \$5.00 will be applied to all accounts not paid within 30 days. A service fee of \$20.00 will be applied to your account for returned checks not paid by your financial institution.

Minor Patients

Wylie Dental Group is not party to any legal settlement resulting from a child support agreement. Responsibility for minor children rests with the parent accompanying the patient at the time treatment is provided. Payment for services rendered to a minor is the responsibility of the parent accompanying the patient. A parent or legal guardian should be present to sign consent for treatment for all patients under the age of 18.

Cancellation Policy

We understand how valuable your time is and will do our best to see you at your appointment time. Appointments are reserved for you. As a courtesy to you, we confirm appointments via text and phone call. We require a 24 hour notice for appointment cancellations. Appointment changes without adequate notice may be subject to a fee starting at \$65.00, payable by the patient and not the insurance company. This fee will increase for repeat offenders and any appointments involving direct care from the doctor including but not limited to consultations and restorative appointments. Patients who repeatedly miss appointments or cancel without proper notification may be dismissed from the practice. However, we will continue to see you for emergency care for 30 days after dismissal.

I have read and understand this policy _____ Date _____



Dental and Personal Questionnaire

1. What prompted you to seek dental care? _____
2. When was your last cleaning or exam at a dental office? _____
3. What was the name of your previous dental office? _____
4. X-rays taken at that time? Yes _____ No _____
5. Do you use a manual _____ or electric toothbrush _____
6. Do you notice bad breath or tastes? _____ Do you gag easily? _____
7. Do your gums bleed or are they painful when brushing or flossing? _____
8. Do you have any loose teeth or trouble chewing? _____
9. Have you ever had gum disease? _____ Was it treated? _____
10. Have you had braces? _____ Name of Orthodontist _____
11. Are you missing any teeth? _____ Where? _____
12. Have you had any cavities in the last three years? _____
13. Are your teeth sensitive to hot, cold, or sweets? Yes _____ No _____
14. Do your teeth hurt while chewing? _____
15. Does your mouth feel dry? _____ Do you have difficulty swallowing? _____
16. Do you get food stuck between any of your teeth? _____
17. Do you breathe through your mouth? Yes _____ No _____
18. Have you ever broken teeth, chipped teeth or had a broken filling? _____
19. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, protein bars or other hard foods?

20. Do you bite your nails, use your teeth to hold objects or have any other oral habits? _____
21. Do you suffer from headaches? _____
22. Does your jaw click, pop or get stuck? _____
23. Do you have any other facial pain? Yes _____ No _____
24. Have your teeth changed in the last five years? _____
25. Are your teeth becoming more crooked, crowded or overlapped? _____
26. Do you clench or grind your teeth? _____
27. Do you snore? _____ Do you wake up during the night and if so how often? _____
28. Do you wake up fatigued? Yes _____ No _____ Do you stop or pause your breathing while sleeping? _____
29. Do you usually drink alcohol or take any sleep aids before bed? Yes _____ No _____
30. Do you wear a night guard, retainer, snore guard or other appliance? _____
31. Have you ever felt self-conscious or uncomfortable about the appearance of your teeth?

32. Are you currently experiencing any other significant dental issues? _____
33. Do you have any nasal allergies? _____
34. Have you had any complications following treatment? _____
35. What can we do to make your treatment more pleasant? _____