

WASHINGTON
SQUARE
DENTAL

1015-E Washington Square • Washington, Mo. 63090 • (636) 239-7828

Fax (636) 239-5048

Welcome to our practice!

We will do everything possible to make your visit to our office a pleasant experience.

Please fill out the enclosed forms and bring them with you to your initial appointment along with your insurance card, co-pay, and/ or payment.

We have two caring dentists at our office. Dr. Melissa Smith is here Mondays through Thursdays, and Dr. Michael Frede is here on Mondays and Wednesdays. Sandi Stege is our skilled full time dental hygienist. If you have recently had x-rays taken at another office, please bring them with you. Otherwise we will take the appropriate x-rays here at our office. After the initial appointment, we will schedule a consultation to discuss how to get you the best smile possible.

Insurance can be very confusing for all of us. Dr. Smith and Dr. Frede are premiere providers for Delta Dental. There are many different Delta Dental plans with different coverage and deductible amounts. We also take other dental insurances which pay out-of-network benefits. It is important to know that your policy is a contract between you and your insurance company, and *not* between us and your insurance company. *Knowing your insurance plan and benefits is your responsibility.* We will be happy to explain your benefits as a courtesy to you. This will help determine what portion of the fees is your responsibility.

Our goal is to help you feel and look your best through excellent dental care. If you are ever unable to keep an appointment we have reserved for you, please notify us at least 24 hours in advance. In the meantime, we look forward to seeing you on a regular basis and serving your dental needs.

Sincerely,



Pam Kellermann, Financial Manager



Lynn Tyree, Appointment Manager



PATIENT INFORMATION

Mr., Mrs., Ms. _____ DATE _____
(First) (Middle Initial) (Last) SEX: M or F Birth Date _____

Preferred name _____ Cell Phone _____
Address: _____ Home Phone _____
Marital Status _____

Social Security # _____ - _____ - _____ E mail _____
Employer: _____ Job Title _____
Employer Address: _____ Work Phone _____

Spouse: _____ Birth Date _____
(if married) (Last) (First) (Middle Initial)

Social Security # _____ - _____ - _____
Employer: _____ Job Title _____
Employer Address: _____ Work Phone _____

IF PARENT IS RESPONSIBLE FOR BILL, WE NEED FATHER AND MOTHER INFORMATION:

Divorced or Separated Spouses. Parent who brings in child for treatment will be responsible for fee at time of service. (We do not handle reimbursement from the other spouse.)

Father: _____ Birth Date _____
(Last) (First) (Middle Initial)

Address: _____ Home Phone _____

Social Security # _____ - _____ - _____
Employer: _____ Job Title _____
Employer Address: _____ Work Phone _____

Mother: _____ Birth Date _____
(Last) (First) (Middle Initial)

Address: _____ Home Phone _____

Social Security # _____ - _____ - _____
Employer: _____ Job Title _____
Employer Address: _____ Work Phone _____

DENTAL INSURANCE INFORMATION

NOTE: PLEASE PRESENT INSURANCE CARD(S) FOR PHOTOCOPY.

Primary Carrier: _____ Secondary Carrier: _____
Insured: _____ Insured: _____
Patient relation: () Self () Spouse () Child Patient relation: () Self () Spouse () Child

REFERRAL INFORMATION

Whom may we thank for referring you to our practice? _____

Another patient, friend Another patient, relative Dental office Yellow Pages Newspaper
 Mailing Work Other _____

(OVER)

HEALTH HISTORY

Has there been any problem in your general health within the past 5 years? (Serious illness, hospitalization, surgery) Yes No

If so, what was the problem and when? _____

Have you had any form of Cancer? Yes No If so, What type or name _____

Date of last medical check-up _____ Date of last blood test _____

Physician _____ Phone # _____

Pharmacy's name _____ Phone # _____

What medications, pills or liquids do you take? (that includes aspirin, vitamins, etc.) _____

Does your physician require you to take special medication before dentistry? Yes No If so, what? _____

Ever had any complications following dental treatment? Yes No

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

	Yes	No		Yes	No
Rheumatic fever, rheumatic heart disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you take or have taken Bisphosphonate ie. Boniva, Actonel, Fosamax _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever taken the drug Phen/Fen _____	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis, other lung ailments _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart trouble, heart attack, stroke _____	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough, cough up blood _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur, Mitral Valve Prolapse _____	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (Type) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	Women: Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
Pain in chest, shortness of breath, swollen ankles _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disorders, anemia _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you sensitive or allergic to: Penicillin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold sores or herpes incident _____	<input type="checkbox"/>	<input type="checkbox"/>	Codeine _____	<input type="checkbox"/>	<input type="checkbox"/>
Positive test for venereal disease _____	<input type="checkbox"/>	<input type="checkbox"/>	Local anesthetics _____	<input type="checkbox"/>	<input type="checkbox"/>
Positive test for HIV/AIDS virus _____	<input type="checkbox"/>	<input type="checkbox"/>	Latex _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding, prolonged healing, bruises easily _____	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin/Ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	Sulfa _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Other drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting spells, seizures _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any disease, condition or problem not listed above that you think the doctor should know about? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis, jaundice, liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	To the best of my knowledge all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.		
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>			
Have you had an orthopedic joint replacement _____	<input type="checkbox"/>	<input type="checkbox"/>	Signature of Patient, Parent or Guardian	Date	
Have you had an organ transplant _____	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney troubles _____	<input type="checkbox"/>	<input type="checkbox"/>			
Are you on blood thinners/Coumadin/ASA _____	<input type="checkbox"/>	<input type="checkbox"/>			

DENTAL HISTORY

Purpose of initial visit _____

Are you aware of any particular dental problems? _____

Any discomfort or pain? _____

Have you ever been diagnosed or treated for periodontal disease? _____

How long has it been since your last visit to a dental office? _____

Services: _____

Do you have bad breath or taste? _____ Gums bleed? _____

How do you clean your mouth? _____

Are you pleased with the appearance of your teeth? _____

If it was possible to change your mouth or teeth what would you change? _____

Consent

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

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

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

Signature: _____ Date: _____

Patient, parent or legal guardian

If signed by patient representative, state relationship to patient _____

WASHINGTON SQUARE DENTAL CARE

ASSIGNMENT AND RELEASE

INSURANCE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. If the balance remaining (after insurance) is not paid in 90 days the account balances and charges will be turned over to a third party collection agency, and the responsible party will be held liable for all legal and collection fees associated with proceedings.

OR

SELF PAY

I, the undersigned, certify that I (or my dependent) is responsible for any outstanding balance. If the balance is not paid in 90 days the account balances and charges will be turned over to a third party collection agency, and the responsible party will be held liable for all legal and collections fees associated with proceedings.

Responsible Party Signature

Date

Relationship