

PATIENT INFORMATION & HEALTH HISTORY

PATIENT INFORMATION:

NAME		DATE	
NAME YOU WISH TO BE CALLED			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
EMAIL			
BIRTHDATE		AGE	
DRIVERS LICENSE NUMBER		STATE	SOCIAL SECURITY NUMBER
EMPLOYER			
BUSINESS ADDRESS			
MARRIED	SINGLE	DIVORCED	WIDOWED
SPOUSE NAME		SPOUSE PHONE NUMBER	
SPOUSE EMPLOYER		SPOUSE WORK PHONE	
SPOUSE BUSINESS ADDRESS			

PARENT OR GUARDIAN INFORMATION:

NAME			
ADDRESS			
CITY	STATE	ZIP	
HOME PHONE	CELL PHONE	WORK PHONE	
BIRTHDATE		AGE	SOCIAL SECURITY NUMBER

DENTAL INSURANCE:

INSURANCE COMPANY		
INSURED'S NAME	INSURED'S DOB	EMPLOYER
INSURANCE ID#	GROUP#	SOCIAL SECURITY NUMBER

GETTING TO KNOW YOU:

HOW WERE YOU REFERRED TO OUR OFFICE	
EMERGENCY CONTACT	
PHONE	ADDRESS

HEALTH HISTORY:

- ARE YOU HAVING PAIN OR DISCOMFORT AT THIS TIME? YES NO
- HAVE YOU BEEN A PATIENT IN THE HOSPITAL IN THE PAST TWO YEARS? YES NO
- HAVE YOU BEEN UNDER THE CARE OF A MEDICAL DOCTOR DURING THE PAST TWO YEARS? YES NO
 PHYSICIAN'S NAME _____

ADDRESS _____ PHONE# _____

- ARE YOU CURRENTLY TAKING ANY MEDICATION? (PRESCRIPTION, HERBAL, OVER THE COUNTER, ETC...) YES NO
 PLEASE LIST _____
- ARE YOU AWARE OF BEING ALLERGIC TO OR HAVE YOU EVER REACTED ADVERSELY TO ANY MEDICATION OR SUBSTANCE? YES NO
 PLEASE LIST _____

- INDICATE WHICH OF THE FOLLOWING YOU HAVE HAD OR HAVE AT PRESENT. CIRCLE "YES" OR "NO" TO EACH ITEM. YES NO

HEART FAILURE	YES	NO	EMPHYSEMA	YES	NO	HEPATITIS A (INFECTIOUS)	YES	NO
HEART DISEASE OR ATTACK	YES	NO	COUGH	YES	NO	HEPATITIS B (SERUM)	YES	NO
ANGINA PECTORIS	YES	NO	TUBERCULOSIS (TB)	YES	NO	LIVER DISEASE	YES	NO
HIGH BLOOD PRESSURE	YES	NO	ASTHMA	YES	NO	YELLOW JAUNDICE	YES	NO
HEART MURMUR	YES	NO	HAY FEVER	YES	NO	BLOOD TRANSFUSION	YES	NO
RHEUMATIC FEVER	YES	NO	SINUS TROUBLE	YES	NO	DRUG ADDICTION	YES	NO
CONGENITAL HEART LESIONS	YES	NO	ALLERGIES OR HIVES	YES	NO	HEMOPHILIA	YES	NO
SCARLET FEVER	YES	NO	DIABETES	YES	NO	VENEREAL DISEASE	YES	NO
ARTIFICIAL HEART VALVE	YES	NO	THYROID DISEASE	YES	NO	COLD SORES	YES	NO
HEART PACEMAKER	YES	NO	X-RAY OR COBALT TREATMENT	YES	NO	FEVER BLISTERS	YES	NO
HEART SURGERY	YES	NO	CHEMOTHERAPY	YES	NO	EPILEPSY OR SEIZURES	YES	NO
ARTIFICIAL JOINTS	YES	NO	ARTHRITIS	YES	NO	FAINTING OR DIZZY SPELLS	YES	NO
ANEMIA	YES	NO	RHEUMATISM	YES	NO	NERVOUSNESS	YES	NO
STROKE	YES	NO	CORTISONE MEDICINE	YES	NO	PSYCHIATRIC TREATMENT	YES	NO
KIDNEY TROUBLE	YES	NO	GLAUCOMA	YES	NO	SICKLE CELL DISEASE	YES	NO
ULCERS	YES	NO	PAIN IN JAW JOINTS	YES	NO	BRUISE EASILY	YES	NO
COSMETIC SURGERY	YES	NO	A.I.D.S.	YES	NO			

- WHEN YOU WALK UP STAIRS OR TAKE A WALK, DO YOU EVER HAVE TO STOP BECAUSE OF PAIN IN YOUR CHEST OR SHORTNESS OF BREATH, OR BECAUSE YOU ARE VERY TIRED? YES NO
- DO YOUR ANKLES SWELL DURING THE DAY? YES NO
- HAS YOUR MEDICAL DOCTOR EVER SAID YOU HAVE CANCER OR A TUMOR? YES NO
- DO YOU HAVE ANY DISEASE, CONDITION OR PROBLEM NOT LISTED? YES NO
 PLEASE DESCRIBE: _____

FOR WOMEN ONLY:

- ARE YOU PREGNANT YES NO
 HOW FAR ALONG _____

I UNDERSTAND THE ABOVE INFORMATION IS NECESSARY TO PROVIDE ME WITH DENTAL CARE IN A SAFE AND EFFICIENT MANNER. I HAVE ANSWERED ALL QUESTIONS TO THE BEST OF MY KNOWLEDGE.

CONSENT:

THE UNDERSIGNED HEREBY AUTHORIZES DOCTOR TO TAKE X-RAYS, STUDY MODELS, PHOTOGRAPHS OR ANY OTHER DIAGNOSTIC AIDS DEEMED APPROPRIATE BY DOCTOR TO MAKE A THOROUGH DIAGNOSIS OF THE PATIENT'S DENTAL NEEDS. I ALSO AUTHORIZE DOCTOR TO PERFORM ANY AND ALL FORMS OF TREATMENT, MEDICATION AND THERAPY THAT MAY BE INDICATED IN CONNECTION WITH DOCTOR'S TREATMENT AND FURTHER AUTHORIZE AND CONSENT THAT DOCTOR CHOOSES AND EMPLOY SUCH ASSISTANCE AS DEEMED IT. I ALSO UNDERSTAND THE USE OF ANESTHETIC AGENTS EMBODIES A CERTAIN RISK. I UNDERSTAND THAT RESPONSIBILITY FOR PAYMENT FOR DENTAL SERVICES PROVIDED IN THIS OFFICE FOR MYSELF OR MY DEPENDENTS IS MINE, DUE AND PAYABLE AT THE TIME SERVICES ARE RENDERED UNLESS FINANCIAL ARRANGEMENTS HAVE BEEN MADE. I FURTHER UNDERSTAND THAT A 1 1/2% FINANCE CHARGE (18% ANNUALLY) WILL BE ADDED TO ANY BALANCE OVER 30 DAYS FROM THE DATE SERVICES ARE RENDERED. IN THE EVENT OF DEFAULT I (WE) PROMISE TO PAY LEGAL INTEREST ON THE INDEBTEDNESS, TOGETHER WITH SUCH COLLECTION COSTS AND REASONABLE ATTORNEY FEES AS MAY BE REQUIRED TO EFFECT COLLECTION OF THIS NOTE.

PATIENT _____ DATE _____ WITNESS _____
 PARENT OR RESPONSIBLE PARTY _____ RELATIONSHIP TO PATIENT _____

David H. Wilhite, DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Nancy

Telephone: 972-964-3774 Fax: 972-867-4557

E-mail: 1davidhw@airmail.net

Address: 5936 West Parker Rd, Suite 1000, Plano, TX 75093

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart.

REVOCAION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

To Our Valued Patients;

Accepting insurance assignment is a courtesy an office extends to its patients and is essentially an interest free loan. We did not mind doing this for our patients in the past, but we are being forced to re-examine the time and effort that goes in to “fixing” what the insurance company “messed” up. Therefore, we are going to continue to accept insurance assignment, but with limits to how much time we can reasonably spend on it once the claim has been submitted. In order to do this we will give you the following two options from which to choose. Please circle one.

1. All payments for services rendered will be paid in full by the patient and our office will take care of filing the insurance asking that the patient be reimbursed. If additional information is requested such as x-rays, narratives, dates of prior treatment, etc, then we will be happy to send that information on to the insurance company as well.
2. The patient will pay what our office estimates to be the co-payment based on our fees and the insurance company’s ceiling for that benefit. If, after 6 weeks from the filing date, the claim has not been paid or if the claim has been paid but the payment is not what was expected, then, our office will automatically charge the balance or difference to the credit card number that has been left on file for use. We will call and let you know when we charge your card. At this point it will be up to the patient to contact the insurance company as to why the claim was not paid or was not paid as expected. If there is a check that eventually comes to us from the insurance company and the patient has a zero balance we will, of course, send a refund check for the difference.

Please understand this is not what we want to do, it has just become so much work that an additional staff member would have to be hired to keep up with the inefficiency of the insurance companies and that would lead to additional costs being passed on to our patients. Thank you for your understanding.

If you would like for us to continue filing your insurance and accept assignment of benefits please sign below. Your signing gives us your signature “on file”.

Visa, M/C, American Express, Discover Please Circle One or Two

Card # _____ Card Code# _____ Expiration _____

Card # _____ Card Code# _____ Expiration _____

My signature authorizes Dr. Wilhite to charge my card for any balance on my account as described above.

Signature _____ Date _____

**This signature will serve for all members of my family