WE CARE DENTAL FL

WELCOME NEW PATIENT

PATIENT INFORMATION

Name _____ Birthdate _____
Last Name First Name Initial

Preferred name _____ Soc. Sec. _____ Phone _____

Address _____ City _____ Zip _____

Sex ☐Male ☐Female ☐Unspecified Marital Status ☐Minor ☐Single ☐Married/Partner

Person Responsible for Account _____ Relationship to Patient _____

Employer /School _____ Work Phone _____

Work Address _____ Occupation _____

Email _____ Who should we thank for referring you? _____

In case of emergency, who should we contact _____ Phone _____

INSURANCE

Subscriber Name _____ Birthdate _____ Soc. Sec. _____

Address _____ Relationship to patient _____

Insurance Company _____ Group # _____ Subscriber/Member ID _____

Insurance Company Address _____ Phone _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage as indicated above and assign directly to We Care Dental Florida 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 payments of benefits. I authorize the use of this signature on all insurance submissions.

Signature _____

Print Name _____

Date _____

DENTAL HISTORY

Former Dentist_____City, State_____ Date of Last Dental Visit_____

How often do you brush?_____floss?_____

How happy are you with your smile _____

Reason for visit_____

Please check all that apply:

Bad Breath ☐	Tooth Pain ☐	Issues Chewing/Swallowing ☐
Bleeding gums ☐	Sensitivity to Hot/Cold ☐	Pain in Jaw/TMJ ☐
Broken/Loose teeth ☐	Sensitivity to Biting ☐	Teeth Grinding/Clenching ☐
Mouth Sores ☐	Frequent Headaches ☐	Clicking/Popping Jaw ☐

	Yes	No
Do you require premedication before dental procedures	☐	☐
Have you ever been treated for periodontal/gum disease	☐	☐
Have you ever had a reaction from local anesthetics such as Novocaine	☐	☐
Are you currently wearing dentures	☐	☐

If yes, age of dentures_____

ALLERGIES

Have you had any allergic reactions to any of the following

	Yes	No		Yes	No		Yes	No		Yes	No
Metal	☐	☐	Sulfa Drugs	☐	☐	Acrylic	☐	☐	Penicillin	☐	☐
Latex	☐	☐	Codeine	☐	☐	Aspirin	☐	☐	Other Antibiotics	☐	☐

Other, please explain_____

PHARMACY (optional)

Pharmacy_____Phone_____Cross-Streets_____

To the extent permitted by applicable law, authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers as applicable and give my pharmacy and insurers permission to disclose such information.

Signature_____

Print Name_____

Date_____

MEDICAL HISTORY

Physician_____Phone_____ Date of Last Visit_____

	Yes	No	
Are you currently under medical treatment?	☐	☐	If yes, please explain_____
Are you taking any medications	☐	☐	If yes, please list_____
Have you ever been hospitalized	☐	☐	If yes, please explain_____
Do you take, or have you taken PhenFen or Redux	☐	☐	
Have you ever taken osteoporosis medications such as Boniva or any medications containing bisphosphates	☐	☐	
Do you smoke	☐	☐	
Do you use controlled substances	☐	☐	

Women are you:

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

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

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Radiation Treatments	Yes	No
Alzheimer's	Yes	No	Diabetes	Yes	No	Hemophilia	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 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 /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	Stom/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 Prolap	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores	Yes	No	Heart Murmur	Yes	No	Pain in Jaw	Yes	No	Tumors or Growths	Yes	No
Convulsions	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Issues	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No

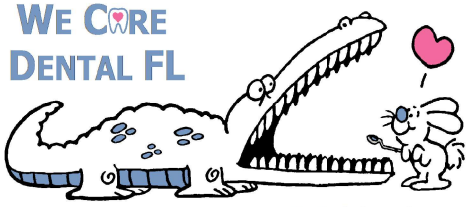
To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature_____

Print Name_____

Date_____

WE CARE DENTAL FL



Dr. B. Linda Ongley, D.M.D.

Cancellation Policy

All appointments canceled less than 24 hours in advance may be subject to a penalty payment of $25 per hour of appointment or as per your insurance regulations for codes D9986 or D9987. If you have any questions regarding this policy, please ask us.

Signature_____

Print_____

Date_____

Notice of Privacy Practices

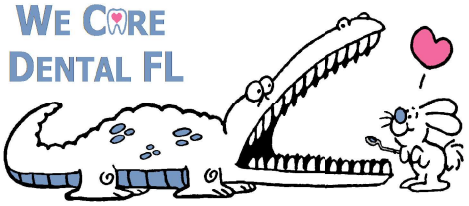
By signing below, I acknowledge that I have provided the Notice of Privacy Practices (separate handout at the end of the New Patient forms), as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Signature_____

Print_____

Date_____

WE CARE DENTAL FL



Dr. B. Linda Ongley, D.M.D.

Financial policies

We Care Dental Florida is committed to providing exceptional service and treatment. We try to make it easier for you to get the care you need with no hidden fees or surprises. Please read the our payment policy and sign below.

You will be given a comprehensive treatment plan based on your overall health. You'll also receive a clear, detailed estimate of the cost of your plan, including your estimated insurance benefits. If you have questions regarding your insurance coverage, please contact your insurance company.

Full payment of what you owe is due when services are rendered.

We accept cash, personal checks, Visa®, Master Card®, American Express®, Discover®, assigned insurance benefits, and select third-party financing programs.

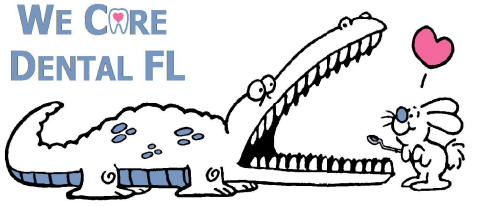
By signing below, I acknowledge that I have read the Financial Policies and agree to abide by such policies.

Signature_____

Print_____

Date_____

WE CARE DENTAL FL



Dr. B. Linda Ongley, D.M.D.

Communication policies

We'd like to keep in touch regarding your upcoming appointments, treatment plan, and treatment status. By providing your email address, phone number, and mailing address, you are giving We Care Dental Florida permission to contact you through one or all of these communication methods.

Note that email and text messaging is not secure and there is a risk that they could be read by a third party. By sharing your email or mobile number with us you are acknowledging that you are aware of this risk and agree to receive this type of communication.

Please rank your preferred communication method:

_____ Email

_____ Mobile phone

_____ Text message

_____ Other, please specify:_____

Authorization for Release of Health Records to External Parties (optional)

This section is regarding sharing my/the patient's treatment information with family or other designated parties.

I authorize the disclosure of information from my treatment records to_____

_____.

I give authorization to disclose the following information:

☐ all treatment information.

☐ information specifically related to these treatment dates _____

Signature_____

Date_____