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

HIPAA

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT INFORMATION:

NAME:_____

ADDRESS:_____

TELEPHONE:_____ALT PHONE_____

EMAIL:_____

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 is available at our front desk.

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 at any time by contacting:

Dr. David Wilhite - ATTN: Office Manager
5936 W. Parker Rd. #1000
Plano, TX 75093

PHONE 972.964.3774
FAX 972.867.4557
EMAIL care@davidwilhitedds.com

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, (PRINT NAME)_____, 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_____

GUARDIAN NAME:_____RELATIONSHIP_____

ADDITION TO PRIVACY POLICY:
I consent to Dr. Wilhite's office sending me information via mail, email or phone to the contact information listed at the top of this page. This may consist of recall cards, promotions, information concerning my appointments, or other forms of communication about the practice and/or my dental health.

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

DAVID H. WILHITE, DDS, MAGD

COSMETIC DENTISTRY • FAMILY DENTISTRY

CANCELLATION POLICY

We consider an appointment is confirmed the day it is made. As a professional courtesy we will remind you via automated text or email.

We ask for at least 24 business hours (*NOTE: we are open Monday-Thursday) for canceling or rescheduling an appointment. Failure to provide us with advance notice may result in a $50 fee per hour scheduled. Cancelations or reschedules must be made during office hours with a staff member. Cancelations or reschedule requests may not be made via email or voice mail.

Keep in mind that we are not a clinic. We are a private practice. The doctor and the hygienist typically see one patient at a time and have very short if any wait times. We do this to provide you with personalized attention and a high standard of care.

A broken appointment is a loss to three people – the patient who missed the time reserved, the patient who could have taken the reserved time and the doctor who was fully staffed and prepared for the appointment.

I hereby agree to Dr. Wilhite's cancelation policy.

_____ _____

SIGNATURE DATE

*EX: Cancelations or reschedule requests for Mondays must be made the prior Thursday during business hours.

MASTER, ACADEMY OF GENERAL DENTISTRY

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