WIBICKI FAMILY DENTAL REGISTRATION

PLEASE PRINT TODAY'S DATE _____

NAME _____ **Social Security #** _____

Address _____ City _____ State _____ Zip _____

Home Phone _____
Cell Phone _____
Business Phone _____
E-MAIL _____

circle Male Female Child
Single Married Divorced Widowed

Date of Birth _____

Name of parent or guardian _____ Name of spouse _____

Employer _____ Business Phone _____
Address _____ City _____ State _____ Zip _____

Spouse's Employer _____ Business Phone _____
Address _____ City _____ State _____ Zip _____

WHOM MAY WE THANK FOR REFERRING YOU OR HOW DID YOU FIND OUR OFFICE?
_____

HIPAA PRIVACY RULE
THE FEDERAL GOVERNMENT RECENTLY ISSUED A REQUIREMENT THAT ALL PATIENTS MUST BE INFORMED OF THEIR RIGHTS OF ENSURED CONFIDENTIALITY OF ANY HEALTH INFORMATION WHICH COULD BE DISSEMINATED AMONG OTHER HEALTH PROFESSIONALS, INSTITUTIONS, INSURANCE COMPANIES OR VENDORS. THE PRIVACY RULE PROVIDES YOU WITH CERTAIN RIGHTS, SUCH AS ACCESS TO YOUR MEDICAL RECORDS. OUR OFFICE HAS A WRITTEN POLICY PLAN WHICH WE CURRENTLY USE TO GUIDE HOW YOUR PERSONAL HEALTH INFORMATION IS HANDLED. THE COMPREHENSIVE DOCUMENT IS AVAILABLE UPON REQUEST AS WELL AS FORMAL DOCUMENTS AND PROCEDURES FOR FILING ANY COMPLAINT WITH U.S HHS. TO ACKNOWLEDGE RECEIPT OF PRIVACY PRACTICE RULES, PLEASE SIGN BELOW.
SIGN: _____ **DATE:** _____

FINANCIAL ARRANGEMENTS
EVERY EFFORT IS BEING MADE TO KEEP DOWN THE BILLING AND ACCOUNTING COSTS OF DENTAL CARE YOU MAY BE ASKED TO MAKE A PAYMENT AT THE TIME DENTAL SERVICES ARE RENDERED. CHECKS, VISA, MASTERCARD AND DISCOVER ARE ACCEPTED. IF TREATMENT REQUIRES MULTIPLE VISITS YOU WILL BE GIVEN AN ESTIMATE AND ASKED TO MAKE FINANCIAL ARRANGEMENTS. WE WILL ATTEMPT TO BE SENSITIVE TO YOUR INDIVIDUAL CIRCUMSTANCES WITHIN THE PARAMETERS OF SOUND BUSINESS PRACTICES. IF YOU HAVE DENTAL INSURANCE WE WILL BE HAPPY TO SUBMIT CLAIMS, PROVIDED ALL THE NECESSARY INFORMATION IS MADE AVAILABLE TO US. YOU WILL BE RESPONSIBLE FOR PAYMENT TO YOUR ACCOUNT REGARDLESS OF INSURANCE COVERAGE INCLUDING CO-PAYMENTS. I HEREBY AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE UNDERSIGNED DENTIST.
SIGNATURE: _____

Signature

DENTAL HISTORY

REASON FOR TODAY'S VISIT: EXAM___ CONSULT___CLEANING___EMERGENCY___
DATE OF YOUR LAST DENTAL CARE VISIT: MONTH_____ YEAR_____
WHAT SERVICES WERE PERFORMED AT THAT TIME? _____
WHEN WAS THE LAST TIME: YOU HAD ANY X-RAYS? MONTH_____YEAR_____
YOU HAD A COMPLETE SET OF X-RAYS (16-18 FILMS)? MONTH_____YEAR_____
YOU HAD YOUR TEETH CLEANED? MONTH_____YEAR_____
HOW OFTEN DID YOUR PREVIOUS DENTIST RECOMMEND CLEANINGS?_____
ARE YOU AWARE OF ANY TREATMENT NOT COMPLETED BY YOUR PREVIOUS DENTIST?___

HAVE YOU NOTICED ANY OF THE FOLLOWING OR HAD THESE PROCEDURES DONE:

YES	NO		YES	NO	
		TEETH TENDER TO CHEW ON			PAIN IN OR NEAR YOUR EYES
		BLEEDING GUMS			SPACES BETWEEN TEETH
		BAD BREATH			SENSITIVITY TO HOT
		SORE AREAS IN MOUTH			SENSITIVITY TO COLD
		LUMP OR GROWTH IN MOUTH			SENSITIVITY TO SWEET
		WORN BRACES/RETAINERS			HAD A ROOT CANAL
		HAD GUM TREATMENTS			WORN NIGHT GUARD
		HAD GUM SURGERY			GUM GRAFTING

IS THERE A REASON WHY MISSING TEETH HAVE NOT BEEN REPLACED?_____
ANY PARTICULAR PREFERENCES?___NOVOCAINE___NO NOVOCAINE___LAUGHING GAS
ANY BAD EXPERIENCES THAT YOU MAY HAVE HAD, WHICH MIGHT AID US IN YOUR TREATMENT

FOR CHILDREN ONLY:
IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST?_____
___

HAS YOUR CHILD HAD ANY BAD MEDICAL OR DENTAL EXPERIENCES?_____

EXPLAIN;_____

IS YOUR CHILD INVOLVED IN A SPEECH THERAPY PROGRAM?_____
IS YOUR CHILD INVOLVED IN A SPECIAL EDUCATION PROGRAM?_____
IS YOUR CHILD INVOLVED IN A PHYSICALLY HANDICAPPED PROGRAM?_____
DOES YOUR CHILD HAVE A FINGER-SUCKING HABIT, OR STILL USE A PACIFIER?_____

DO YOU HAVE ANY REQUESTS OR COMMENTS WHICH MIGHT ASSIST US IN THEIR TREATMENT

PERMISSION TO TREAT CHILD: SIGNATURE PARENT/GUARDIAN_____

Signature