Patient Information & Health History Form

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Email: _____ Employer: _____

Social Security #: _____ Birth Date: _____

Phone #: Cell: _____ Home: _____

Work: _____ Other: _____

Address:
Street City State Zip Code

If you are a New Patient whom may we thank for referring you to our practice? ☐ **Name** _____
☐ **Website/Internet** ☐ **Yellow Pages** ☐ **Sign/driving by** ☐ **Insurance** ☐ **Other** _____

Date of Last Dental Visit: _____ Reason for today's visit: _____

Medical Health History

For the following questions, check YES or NO, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

Are you now under the care of a physician: ☐ Yes ☐ No If so, what is the condition being treated? _____

Emergency Contact: _____ Relationship: _____ Phone #: (_____) _____

Physician Name: _____ Phone #: (_____) _____

Preferred Pharmacy: _____ Phone #: (_____) _____

Have you been admitted to a hospital or needed emergency care during the past five years?..... ☐ Yes ☐ No
If so, what was the illness/injury? _____
Do you have chest pain upon exertion?..... ☐ Yes ☐ No
If so, please explain: _____
Are you ever short of breath after mild exercise or when lying down?..... ☐ Yes ☐ No
If so, please explain: _____
Do you drink alcoholic beverages?..... ☐ Yes ☐ No
If yes, how much?: _____
Do you smoke or use tobacco products?..... ☐ Yes ☐ No
If yes, please list: _____
Do your ankles swell?..... ☐ Yes ☐ No
Do you have inborn heart defects?..... ☐ Yes ☐ No
Are you taking ANY medicine(s) including non-prescription?..... ☐ Yes ☐ No
If yes, please list or attach a medication list: _____
Do you have any health problems that need further clarification?..... ☐ Yes ☐ No
If so, please explain: _____

Female Patients: Are you pregnant or is there a chance you could be pregnant? ..... ☐ Yes ☐ No
If yes, what is your due date? ____/____/_____

Are you allergic or have you had a reaction to any of the following?:

Amoxicillin.....	☐ Yes	☐ No	Ibuprofen	☐ Yes	☐ No	Sulfa.....	☐ Yes	☐ No
Antibiotic	☐ Yes	☐ No	Iodine.....	☐ Yes	☐ No	Tetanus.....	☐ Yes	☐ No
Aspirin.....	☐ Yes	☐ No	Latex.....	☐ Yes	☐ No	Tramadol.....	☐ Yes	☐ No
Bactrim.....	☐ Yes	☐ No	Local Anesthetic.....	☐ Yes	☐ No	Tylox.....	☐ Yes	☐ No
Codeine.....	☐ Yes	☐ No	Lortab.....	☐ Yes	☐ No	Other: _____		
Compazine.....	☐ Yes	☐ No	Nickel.....	☐ Yes	☐ No	_____		
Erythromycin	☐ Yes	☐ No	Penicillin.....	☐ Yes	☐ No			

 Patient Name: _____

Do you have or have you ever had any of the following? Please check those that apply:

Acid Reflux…… ☐ Yes ☐ No
AIDS/HIV…..... ☐ Yes ☐ No
Alcohol Dependency... ☐ Yes ☐ No
Anemia …… ☐ Yes ☐ No
Arthritis …… ☐ Yes ☐ No
Artificial Heart Valve… ☐ Yes ☐ No
Artificial Joints…… ☐ Yes ☐ No
Asthma…… ☐ Yes ☐ No
Blood Disease…… ☐ Yes ☐ No
Blood Thinners…… ☐ Yes ☐ No
Blood Transfusion..... ☐ Yes ☐ No
Cancer…… ☐ Yes ☐ No
ChemicalDependency ☐ Yes ☐ No
Dental Implants..... ☐ Yes ☐ No
Diabetes…… ☐ Yes ☐ No
Emphysema…… ☐ Yes ☐ No
Epilepsy…… ☐ Yes ☐ No
Excessive Bleeding…. ☐ Yes ☐ No
Fainting/Dizziness..... ☐ Yes ☐ No
Head Injuries…… ☐ Yes ☐ No
Heart Disease…… ☐ Yes ☐ No
Heart Murmur…… ☐ Yes ☐ No
Hepatitis…… ☐ Yes ☐ No
Type _____
Herpes…… ☐ Yes ☐ No
High Blood Pressure.... ☐ Yes ☐ No
High Cholesterol…… ☐ Yes ☐ No
Kidney Disease…… ☐ Yes ☐ No
Knee Replacement..... ☐ Yes ☐ No
Liver Disease…… ☐ Yes ☐ No
Low Blood Pressure… ☐ Yes ☐ No
Low Blood Sugar…… ☐ Yes ☐ No
Lupus…… ☐ Yes ☐ No
Mental Disorders…… ☐ Yes ☐ No
Mitral Valve Prolapse... ☐ Yes ☐ No
Nervous Disorders..... ☐ Yes ☐ No
Pacemaker…… ☐ Yes ☐ No
Persistent cough…… ☐ Yes ☐ No
Problem with Immune System…… ☐ Yes ☐ No
Problem with Swollen Glands…… ☐ Yes ☐ No
Radiation Treatment... ☐ Yes ☐ No
Respiratory Problems. ☐ Yes ☐ No
Rheumatic Fever…… ☐ Yes ☐ No
Rheumatism…… ☐ Yes ☐ No
Scarlet Fever…… ☐ Yes ☐ No
Seasonal Allergies….. ☐ Yes ☐ No
Seizures…… ☐ Yes ☐ No
Sexually transmitted Disease…… ☐ Yes ☐ No
Sinus Issues…… ☐ Yes ☐ No
Sleep Apnea…… ☐ Yes ☐ No
Stomach Problems….. ☐ Yes ☐ No
Stroke…… ☐ Yes ☐ No
Thyroid Disorder…… ☐ Yes ☐ No
Tuberculosis…… ☐ Yes ☐ No
Ulcerative Colitis…... ☐ Yes ☐ No
Ulcers…… ☐ Yes ☐ No

OTHER:
☐ _____
☐ _____
☐ _____

Dental Health History

Have you had any trouble/complications following any previous dental treatment?..... ☐ Yes ☐ No
If so, please explain: _____
Do you suffer from any TMJ problems?..... ☐ Yes ☐ No
Are you wearing any removable dental appliances?..... ☐ Yes ☐ No
Does your physician require you to premedicate with antibiotic for dental treatment?..... ☐ Yes ☐ No
If so, what medication? _____

☐ Bad Breath
☐ Bleeding gums
☐ Blisters on lips or mouth
☐ Broken fillings
☐ Cigarette, pipe or cigar smoking
☐ Dry mouth
☐ Food collection between teeth
☐ Grinding teeth
☐ Gums swollen or tender
☐ Jaw pain or tiredness
☐ Loose teeth
☐ Orthodontic treatment
☐ Pain around ear
☐ Periodontal treatment
☐ Sensitivity to cold
☐ Sensitivity to heat
☐ Sensitivity to sweets
☐ Sensitivity when biting
☐ Sores or growths in mouth
☐ Sleep Apnea
☐ Other: _____

How often do you brush: _____
How often do you floss: _____

Rate Your Smile: (Love It) 10 9 8 7 6 5 4 3 2 1 (I don't like it at all)

Insurance Information

Primary

Name of Policy Holder:_____ Date of Birth _____

Insurance Plan Name and Address: _____

ID #_____ Group # _____ Patient's relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer Name: _____

Secondary

Name of Policy Holder:_____ Date of Birth _____

Insurance Plan Name and Address: _____

ID # _____ Group #_____ Patient's relation to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured's Employer Name: _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form, and I understand the HIPAA regulatory laws and have received a copy of the HIPAA policy for this office. If I ever have any change in my health or HIPAA consent, I will inform the doctors at the next appointment without fail.

_____ **Date:** _____

Signature of patient, parent or guardian

Patient Name: _____

Scott Wagner, DDS, P.C. **(918) 622-3915**
9035 E 62nd Street, Tulsa, OK. 74133 **www.scottwagnerdds.com**

HIPAA Authorization Form for Family Members/Friends

I give my permission to Wagner Family & Cosmetic Dentistry and Dr. Scott Wagner and his staff to disclose and release my protected health information and all past, present and future health record (including but not limited to diagnoses, lab tests, prognosis, treatment, billing, insurance and appointment records for all conditions, treatment, procedures and financials) to:

Name(s):	Relationship:
_____	_____
_____	_____

_____ I do not give permission to share any past, present and future health record with any person(s) other than other health care providers should the need arise.

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

Consent to Leave Message

Wagner Family & Cosmetic Dentistry and Dr. Scott Wagner and his staff in order to comply with the HIPAA Privacy Regulation, requires an authorization from the patient before detailed messages are left for the patient. This policy is to protect the privacy of the patient and to protect our office and staff from violating the patient's confidentiality. If there is not a signed consent on file, we will only leave our name and phone number on an answering machine, voicemail or with a live person answering the phone requesting the patient to return our call.

By completing the consent below, you are allowing Wagner Family & Cosmetic Dentistry, Dr. Scott Wagner and his staff to leave a message on an answering machine, voicemail or with a specified individual. You may specify what information is left and with whom by noting the information on the bottom of this form. By signing, you are also consenting to the mailing, emailing or faxing of any results, requested by you, to your primary care physician or another physician involved in your care.

_____ **I give permission to leave relevant medical, financial and appointment information on my answering machine or voice mail at home, cell phone, work or with the person(s) I have listed above.**

_____ **I do not give my permission to leave relevant medical, financial and appointment information on my answering machine or voice mail at home, cell phone or work. I understand that Dr. Wagner and/or his staff will only leave basic information and I will need to return their call for more details.**

_____
Name of the Individual Giving this Authorization

_____ _____
Signature of the Individual Giving this Authorization Date

Wagner Family & Cosmetic Dentistry
Appointment Policy

In an effort to reduce wait times and provide a great patient experience, we have an Appointment Policy. When an appointment is scheduled, a specific amount of time has been set aside for you. At Wagner Family & Cosmetic Dentistry we want to make sure that you have access to high-quality dental care when you need it. To ensure maximum access to dental services for all of our patients, please be aware of the following appointment policy:

Confirmations: We make every attempt to see our patients on time. We do **REQUIRE** confirmation of all appointments which are done via text, email and/or phone call. A confirmed appointment is a promise that you will be able to make it to your appointment. Confirmation must be made within 24 business hours of your scheduled appointment, or your appointment may be given to another patient awaiting treatment. Please note that we will make every attempt to contact you prior to removing you from our schedule.

Cancelled Appointments: If you cannot keep your scheduled appointment, you must call us at least 24 hours in advance to cancel/reschedule. This allows us enough time to offer your appointment to another patient on our waiting list. Same day cancellations will count as a missed appointment and a $50 fee will apply.

Missed Appointments: Missed appointments will be documented in your dental record. For any missed appointments or cancellations made with less than a 24 hour notice, there will be a charge of $50 billed to your account. This fee must be paid prior to your next appointment. This fee cannot be billed to your insurance company and will be your direct responsibility.

Late Arrivals: If you arrive more than 15 minutes late for your scheduled appointment, it will count as a missed appointment, a $50 fee will apply and your appointment will be rescheduled after this fee is paid.

We understand unforeseen circumstances arise, and we will take your situation into consideration. We realize accidents happen, family members get sick, and emergencies occur. We will do our best to accommodate these rare occasions with grace, but please remember we track these occurrences as to prevent abuse of the policy.

If you have any questions about the Cancellation, No Show and Late Arrival Policy, please speak with any of the dental staff.

I understand and agree to abide by this cancellation, No Show and Late Arrival Policy.

_____

Patient Name

_____ _____

Patient Signature Date

_____

Parent/Guardian Name (for patients under 18 years of age)

_____ _____

Parent/Guardian Signature (for patients under 18 years of age) Date

Scott Wagner, DDS, P.C. **(918) 622-3915**
9035 E 62nd Street, Tulsa, OK. 74133 **www.scottwagnerdds.com**

FINANCIAL POLICY

OFFICE FINANCIAL POLICIES

WELCOME to our office. One of our goals is to make your financial portion simple and easy to understand. We want to provide you with a clear understanding of how your insurance benefit package works, and our office financial policies. Signing this document means you understand the financial policies, you consent to the terms, and all of your questions regarding your benefits have been answered.

1. I understand that payment is due at the time of service.

2. I understand Dr. Wagner accepts most insurance companies. I understand that Dr. Wagner and/or his staff will file with my insurance company as a courtesy to me. I understand that even if given an estimate of my coverage, Dr. Wagner and/or his staff cannot guarantee that the insurance company will provide the full estimated coverage and that I will be responsible for any portion the insurance company does not cover.

3. I understand that in the event of a balance due, Dr. Wagner and/or his staff will bill me at 30, 60, and 90 days. After 90 days, I will be referred to a collection agency. In the event of litigation by Dr. Wagner and/or his staff or its collection agency to enforce collection of any outstanding debt, I will be responsible for all reasonable attorney and collection agency fees, billing fees, late fee and a collection charge of $25.00.

4. There is a charge of $30.00 for any returned checks.

5. Payment options include: MasterCard, Visa, Discover, check, cash, cashier's check or money order. Dr. Wagner and/or his staff also offer financing options with several third-party financing companies.

CONSENT AND AGREEMENT

1. As a consenting adult, I agree to permit Dr. Wagner and/or his staff to provide comprehensive dental care to myself, child (children), or legal ward as applicable. Comprehensive dental care (examination) includes soft and hard tissue exam of the head and neck, periodontal (gum) exam, oral cancer screening, and X-rays (full mouth).

2. I understand that Dr. Wagner and/or his staff maintains the right to discontinue dental treatment for any appropriate reasons such as refusal of X-rays, refusal of dental exams, refusal of periodontal treatment, excessive cancellations, failed appointments or failure to pay. In such cases, the patient or parent/guardian agrees to accept full responsibility for pursuing alternate dental care. A letter shall be sent informing you that treatment is discontinued.

3. I understand there may be a $50.00 charge per person for all failed appointments or cancellations without a 24 hour notice. This charge is not covered by my insurance and I am personally responsible for the payment of this fee. (We request that you call in advance upon changes in your schedule so that other patients would be allowed to come in your reserved time slot)

4. I understand that all records pertaining to the treatment and diagnosis of are the property of Scott W. Wagner, DDS, P.C.

5. I understand that Dr. Wagner and/or his staff will conduct a comprehensive periodontal evaluation on a yearly basis, bitewing x-rays at minimum once a year and a full mouth or Pano x-ray every 3-5 years which may or may not be covered by my insurance and that I am responsible for any and all portions not covered by my insurance plan.

6. I understand that a parent or guardian must sign consent for treatment of a minor. YOU ARE REQUIRED TO BE ON THE PREMISES DURING THE ENTIRE SESSION OF ALL DENTAL CARE (EXAMS, X-RAYS, OR TREATMENT) FOR THE MINOR. Dr. Wagner and/or his staff will not treat minor children without a parent/guardian present at the time of service.

7. I will be expected to pay for treatment I receive and that Dr. Wagner and/or his staff reserves the right to revise fees at any time, for any treatment which has not been started. During the course of my dental care unforeseen complications or new conditions may arise that may require treatment in addition to the procedures listed on my treatment plan which may result in higher cost. I understand that in the event my treatment becomes too complex to manage, it may be necessary for me to be referred to one of the specialists in order for me to receive the appropriate care. Should this occur, I understand that I will be expected to pay the specialist's fee.

8. I understand that any quoted financial plans I receive are valid for 90 days and are subject to change after that time period

9. I hereby give my consent for Dr. Wagner and/or his staff to send reminders to my mobile device and/or email address and that these messages may include a reminder of a previously scheduled appointment or a notification that I need to schedule an appointment. I understand that I can opt out of these messages by notifying a staff member or by replying "STOP" to the message and that text message charges from my cell phone carrier may apply.

I understand the consent and the office financial policies. I consent to the terms of agreement and that all of my questions regarding the financial portion, and consent and agreement have been answered to my satisfaction. I have read the above conditions of treatment and payment and agree to their content.

ACKNOWLEDGEMENT OF THE HIPPA PRIVACY ACT POLICY: I have received a copy of this offices Notice of Privacy Practices.

_____ _____

Patient (guardian if patient is a minor) Date

_____ _____

Witness Date