New Patient Registration

Aaron Wellborn, DMD
FAMILY DENTAL SOLUTIONS

Appointment date & time: _____

Patient

Name: _____ Birth date: _____ SS #: _____

Address: _____
Street City State Zip code

Mailing Address (if different:) _____
Street City State Zip code

Phone 1: _____ ☐ Hm ☐ Cell ☐ Wk Phone 2: _____ ☐ Hm ☐ Cell ☐ Wk

Email: _____

☐ Patient is a college student. Name of college/university: _____

Year in school: _____ Status: ☐ Full time ☐ Part time ☐ ¾ time

Responsible Party (if other than patient)

Name: _____ Birth date: _____ SS#: _____

Address: _____
Street City State Zip code

Phone 1: _____ ☐ Hm ☐ Cell ☐ Wk Email: _____

Insurance

Primary Insurance carrier: _____ Plan name: _____

Group #: _____ ID#: _____

Customer Service Phone: _____ Address: _____

Name of insured: _____ Date of Birth: _____

Employer: _____ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Secondary Insurance carrier: _____ Plan name: _____

Group #: _____ ID#: _____

Customer Service Phone: _____ Address: _____

Name of insured: _____ Date of Birth: _____

Employer: _____ Relationship to patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other

Pre-Appointment

How did you hear about us: _____

Reason for appointment: _____ Areas to watch: _____

Previous dentist: _____ Phone number: _____

☐ Patient requires pre-medication for dental work. Reason: _____

Pharmacy: _____ Number: _____

Comments:

Please list any comments or concerns you may have: _____

Dr. Aaron Wellborn | 22526 SE 64th Place, Suite 110, Issaquah, WA 98027
P:425.427.1850 F:425.427.1870 | WWW.WELLBORNDENTISTRY.COM

Dental and Medical History

Aaron Wellborn, DMD
FAMILY DENTAL SOLUTIONS

Patient Name: _____ Birth date: _____

☐ Adult ☐ Child ☐ Male ☐ Female

DENTAL HISTORY

How often do you brush? _____

How often do you floss? _____

☐ Apprehensive about dental treatment
☐ Gag easily
☐ Food catches between teeth
☐ Difficulty chewing food/uncomfortable bite
☐ Avoid brushing any part of mouth
☐ Gums bleed during flossing
☐ Gums feel swollen or tender or bleed easily
☐ Sensitive teeth when come in contact with:
☐ Hot ☐ Cold ☐ Sweet ☐ Sour
☐ Grind teeth or clench jaw frequently
☐ Jaw makes noise that is bothersome or gets stuck
☐ Earaches or pain in front of ears
☐ Pain in face, cheeks, jaw, throat, or temples

Additional Dental:

☐ I use an electric toothbrush
☐ I have been treated for periodontal disease
☐ I wear dentures
☐ I prefer treatment with nitrous oxide to help reduce anxiety
☐ I have temporomandibular disorder (TMD)
☐ I would like to be evaluated for any jaw disorders
☐ I have been diagnosed with TMD/TMJ
☐ I am interested in learning more about the benefits of a night guard or occlusal guard
☐ I am interested in learning more about the benefits of a device to help reduce snoring
☐ I am dissatisfied with the appearance of my teeth
☐ I would like a cosmetic consultation (Select all applicable)
☐ straightening ☐ replace fillings/crowns ☐ whitening
☐ I would like more information about an implant or a bridge

MEDICAL HISTORY

☐ No ☐ Yes, **I do require antibiotic pre-medication** for dental appointments.
☐ No ☐ Yes, I am currently under a physician's care for: _____
☐ No ☐ Yes, I have been hospitalized or have a major operation for: _____
☐ No ☐ Yes, I have had a serious head or neck injury.
Women: ☐ No ☐ Yes, I am taking hormones/contraceptives.
Women: ☐ No ☐ Yes, Pregnant – Due Date: _____

ALLERGIES TO THE FOLLOWING:

☐ Local anesthetics ("Novocain")
☐ Penicillin or other antibiotics
☐ Sulfa drugs
☐ Barbiturates, sedatives or sleeping pills
☐ Aspirin, Acetaminophen, or Ibuprofen
☐ Codeine, Demerol, or other narcotics
☐ Reaction to metals
☐ Latex or rubber dam
☐ Other _____

TAKEN IN THE PAST 12 MONTHS:

☐ Antibiotics or sulfa drugs
☐ Anticoagulants/Blood Thinners (e.g. Coumadin)
☐ High blood pressure medication
☐ Tranquilizers
☐ Insulin, Orinase, or similar drug
☐ Aspirin
☐ Digitalis or drugs for heart trouble
☐ Nitroglycerin
☐ Nonprescription drugs or supplements (please list on back of form)

Please check the box if any of the following applies to you:

☐ Asthma; Breathing or Respiratory Problems
☐ Persistent Cough
☐ Swollen Glands or Tonsillitis
☐ Herpes/Cold Sores/Fever Blisters
☐ Sinus Trouble
☐ Excessive Thirst
☐ Vision Disorder
☐ Head/Neck Injury
☐ Frequent Headaches
☐ Fainting Spells or Epilepsy or Seizures
☐ Heart Disease or Stroke or Heart Attack
☐ Congenital Heart Disorder
☐ Irregular Heartbeat
☐ Mitral Valve Prolapse
☐ Pacemaker
☐ Artificial Heart Valve
☐ Heart Murmur
☐ High Blood Pressure
☐ Low Blood Pressure
☐ Lung Disease
☐ Kidney Disease
☐ Liver Disease
☐ Rheumatic or Scarlet Fever
☐ Hemophilia or Excessive Bleeding
☐ Anemia/Bruise Easily
☐ Other Blood Disease
☐ Anaphylaxis
☐ Hives or Rash
☐ Shingles
☐ Nervous Disorder
☐ Artificial Joint
☐ Arthritis or Gout
☐ Cancer
☐ Chemotherapy
☐ Radiation Treatment
☐ Diabetes
☐ Hepatitis
☐ AIDS/HIV Positive
☐ Psychiatric Care
☐ Stomach Problems or Ulcers

Please use the back of the back of this form to list and explain any serious illnesses you have had that are not listed above.

☐ More information on the back of this form

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 Dr. Wellborn's office of any changes in my medical status.

_____ _____

Patient or responsible party signature Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES *(and other fine print…)*

HIPPA Policy:

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

I understand that this office uses e-mail, text and collection services for business purposes.

_____
Initial

Financial Policy:

All payment is due at the time of service and as the patient you are responsible for all charges. However, if you are a patient with documentation of private insurance, as a courtesy we will bill your insurance policy for you at no charge. Please plan to pay your deductible and any applicable co-pay at the time of service.

As a service to our patients, we are happy to estimate your out-of-pocket portion for any given procedure. We will do our best to provide your plan's eligibility and benefit information, but there are no guarantees (even with a direct pre-authorization from your insurance).

Chair Reservation Policy:

As a small office, all missed appointments or late arrivals harm our ability to serve each of our patients effectively.

All patients must call to cancel or change appointments in advance so that we may offer longer breaks to our employees or offer the time to a patient who may need it. We understand that this is sometimes not possible. However, patients who fail to call or reschedule without 2 full business days' notice or patients who do not show up for the scheduled appointment will be charged a $59.00/hr fee for EACH occurrence.

If you fail to arrive within 10 minutes of your scheduled appointment time, we may consider that a "missed appointment" to ensure we give both you and those after you adequate time for scheduled treatment.

Bounced Check Policy:

We gladly accept payment in the form of a personal check, however, returned checks due to insufficient funds will be subject to a $25 fee payable by cashier's check or credit card.

I fully understand that I am responsible for all charges in the event of non-payment by my insurance company. I have read and understand the HIPAA, Financial, Chair Reservation, and Bounced Check Policies. I give consent for the office of Aaron J. Wellborn, DMD to bill my insurance and receive payment directly from them. I agree to notify the office in the event of change of address, telephone number, employment or insurance coverage.

_____ _____
Patient Name Date

_____ _____
Patient or responsible party signature Relationship to patient

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices and Chair Reservation Policy due to the following reason:

☐ The patient refused to sign ☐ Communication barriers ☐ Emergency situation ☐ On record for responsible party

☐ Other: _____

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