We would like to welcome you to our office. Our goal is to make everyone's visit pleasant and educational. We strive to teach good oral care that will enable you to have a beautiful smile that last a lifetime. Please visit us at www.sawgrassdental.com

1 Patient Information

Today's Date ____________

First Name ______________________ MI ______

Last Name ______________________

Birthdate __________ Age ____ SS# ____________

☐ Married ☐ Single ☐ Widowed ☐ Divorce ☐ Separated

Address ______________________

____

Home # ____________ Cell # ____________

Employer ____________ Work # ____________

Occupation ______________________

Email ______________________

Referred by ______________________

2 Responsible Party

First Name ______________________ MI ______

Last Name ______________________ ☐ M ☐ F

Birthdate __________ Age ____ SS# ____________

Employer ____________ Work# ____________

Occupation ______________________

Employer's Address ______________________

____

3 Primary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone ______________________

Plan ____________ Group ____________ Policy ____________

Policy Owners Name ______________________

Relationship to Patient ______________________

Policy Owners Birthdate ____________ SS# ____________

Policy Owners Employer ______________________

Employees Address ______________________

Orthodontic Coverage? ☐ Yes ☐ No

4 Secondary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone ______________________

Plan ____________ Group ____________ Policy

Policy Owners Name ______________________

Relationship to Patient ______________________

Policy Owners Birthdate ____________ SS# ____________

Policy Owners Employer ______________________

Employees Address ______________________

Orthodontic Coverage? ☐ Yes ☐ No

5 Dental History

Purpose of todays visit ______________________

Previous dentist ______________________

When was your last visit ______________________

What was done ______________________

Last Cleaning ______________________

How often do you brush ________ Gums bleed ☐ Yes ☐ No

Any ☐ Sensitive teeth ☐ Loose teeth ☐ Broken Fillings ☐ Jaw pain ☐ Injuries to teeth

Explain ______________________

Unpleasant Dental Experience ☐ Yes ☐ No

Explain ______________________

Have you ever had ☐ Orthodontics ☐ Gum Treatment ☐ Root Canal ☐ Oral Surgery ☐ Crowns ☐ Veneers ☐ Implants

Are you happy with the appearance of your teeth?
☐ Yes ☐ No ☐ Color ☐ Position ☐ Smile

Have you ever had tooth whitening? ☐ Yes ☐ No
☐ In Office ☐ Overnight ☐ Drug Store

Are you interested in replacing any missing teeth? ☐ Yes ☐ No

Which method ☐ With Dentures ☐ Bridges ☐ Implants

Do you have any questions for the doctor? ☐ Yes ☐ No

(please continue on back)

I authorize the doctor to perform all recommended treatment agreed upon by me and to use the appropriate medication and therapy for such treatment in connection with ______________________ (NAME OF PATIENT). I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and give consent to the doctor to use and employ such assistant as deemed fit to provide recommended treatment.

6 Medical History

Physicians Name ______________________

Office Address ______________________

Telephone ______________________

Are you currently under the care of a physician? ☐ Yes ☐ No

Explain ______________________

Has there been a recent change to your health? ☐ Yes ☐ No

Explain ______________________

Are you currently taken any prescription, over the counter of recreational drugs? ☐ Yes ☐ No

Explain ______________________

Have you been hospitalized or had a serious illness within the past five years? ☐ Yes ☐ No

Explain ______________________

Please mark any allergies/adverse reactions:

Y N Penicillin
Y N Tetracycline
Y N Erythromycin
Y N Sulfa
Y N Local Anesthetics
Y N Codeine
Y N NSAID (Advil/Motrin)
Y N Aspirin
Y N Valium
Y N Barbiturates
Y N Latex
Y N Iodine
Y N Household Bleach
Other ______________

Do you?

☐ Smoke Packs Per Day? ______ How Long? ______
☐ Chew Tobacco
☐ Drink Per Week? ______ Per Month? ______
☐ Wear Contact Lenses

a) Are you pregnant or think you may be pregnant? ....Y N
b) Are you nursing? ....Y N
c) Are you taking oral contraceptives?....Y N

Check if you have or ever had

Y N Artificial Limb/joint/hip
Y N High/low Blood Pressure
Y N Organ Transplant
Y N Sinus Problems
Y N Migraines
Y N Frequent Headaches
Y N Claustrophobia
Y N Artificial Heart Valve
Y N Prolonged Bleeding
Y N Ulcers/colitis
Y N Hay Fever
Y N Head Injury
Y N Venereal Disease
Y N Mitral Valve Prolapse
Y N Anemia
Y N Acid Reflux
Y N Arthritis
Y N Epilepsy/seizures
Y N STD
Y N Rheumatic Fever
Y N Radiation Therapy
Y N Stomach Problems
Y N Glaucoma
Y N Dizziness/Fainting Spells
Y N Treated For AIDS, HIV, ARC
Y N Heart Murmur
Y N Thyroid Problems
Y N Used Phen Phen
Y N Chronic Diarrhea
Y N Stroke TIA
Y N Joint Surgery
Y N Cancer/chemotherapy
Y N Blood Disorder
Y N Increased Frequent Urination
Y N Bells Palsy
Y N Heart Disease
Y N Diabetes
Y N Asthma
Y N Night Sweats
Y N Psychiatric Or Emotional
Y N Recurrent Infections
Y N Angina
Y N Kidney Problems
Y N Bronchitis
Y N Addictions
Y N Pace Maker
Y N Liver Problems
Y N Emphysema
Y N TMJ Problems
Y N Shortness Of Breath
Y N Hepatitis: A or B or C
Y N Tuberculosis
Y N Unexplained Weight Loss
Y N Mouth Ulcers

7 Office Policy

We reserve the right to charge for any cancelled appointments if we do not receive 48 hours notice. All accounts sent to collections will be charged the account balance plus an additional 50% based on the account balance. Regardless of insurance, patients are fully responsible for any account balance. Patients are encouraged to ask all relevant dental & medical questions and thus fully understand the cost, time, limitations, and potential complications of any dental care they agree to receive. The dental profession can not be responsible for any treatment failures that are the result of patient neglect, injury or abuse. By my signature I hereby do certify that: I have read and understood the office policy. All information I have provided is accurate. I will update the office regarding any changes in this information. I will not hold any member of the dental staff responsible for actions resulting from any errors or omissions that I have made in the completion of this form. *Note: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.* I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold my dentist, or any other member of his or her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Our Legal Duty: We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/2003 and will remain in effect until we replace it.

Accept Assignment: My signature authorizes the release of necessary information needed to process my claim, and to pay benefits to the provider of service.

______________________ SIGNATURE OF PARENT OR GUARDIAN ______ DATE

8 For Completion By Dentist

Comments on patient interview concerning health history

____

____

____

Significant findings from questionnaire or oral interview

____

____

____

Dental Management considerations

____

____

______________________ SIGNATURE OF DENTIST ______ DATE

SECTION 3

Dental History (Patient To Fill Out Completely)

Primary reason for this dental appointment: ☐ Examination ☐ Emergency ☐ Consultation

Date of your last dental visit ____________ For what? ____________

Date of your last dental cleaning ____________

	Yes	No
Do you have a specific dental problem? Describe ____________	☐	☐
What kind of dental procedures have you had done in the past? ____________	☐	☐
Do you have any sensitive teeth? ____________	☐	☐
Have you ever had a toothache or a fractured tooth? ____________	☐	☐
Have you ever had periodontal problems? ____________	☐	☐
Do you like your smile? Why? ____________	☐	☐
Does food catch between your teeth or do you have areas that are difficult to floss? ____________	☐	☐
Does loss of teeth tend to run in your family? ____________	☐	☐
Do you ever have clicking, popping or discomfort in the jaw joint? Do you brux or grind? ____________	☐	☐
Have you ever had Orthodontics (Braces)? ____________	☐	☐
Have your past experiences in a dental office always been positive? ____________	☐	☐
Do you smoke or chew tobacco? Any sores or growths in your mouth? Describe ____________	☐	☐
Name of previous dentist (Optional) ____________	☐	☐
Why did you leave your last dentist? ____________	☐	☐
Have you noticed spots or stains on your teeth that concern you? ____________	☐	☐
Anything else that concerns you about the appearance of your teeth? ____________	☐	☐

If you could change anything about your smile, what would you change? ____________

____

Do you have a denture or partial denture? ☐ No ☐ Yes How old are they? ______ How do you like them? ______

____

Have you ever required Nitrous Oxide (Laughing Gas) or sedatives for your dental treatment? ____________ ☐ ☐

Check Your Level of Bravery: Don't Worry, We Cater To Cowards

☐ ☐ ☐ ☐ ☐

SECTION 4

Initial Clinical Exam (I.C.E.)

Date: ____________ Patient Name: ____________

Blood Pressure: ______ : ______

Stains:	☐No	☐Lt	☐Mod	☐Hvy
Calculus:	☐No	☐Lt	☐Mod	☐Hvy
Plaque:	☐No	☐Lt	☐Mod	☐Hvy
Bleeding:	☐No	☐Lt	☐Mod	☐Hvy

TMJ: ☐Asymptomatic ☐Symptoms: ____________

Homecare: Brushing: ____ x/day Floss: ______ x/week

Perio Diag: ☐Normal ☐Gingivitis ☐Early Perio ☐Mod Perio ☐Adv Perio ☐Maint

Instructions: ☐Brush ☐Floss ☐Perio Aid ☐Other: ____________

Ortho: Occlusal Type: ☐CLI ☐CLII ☐CL III

Soft Tissue Screening

Cancer Exam: ☐Normal ☐Lesion: Describe ____________

See dental history for smoking history

	Normal	*Abnormal*
Lips	☐	☐ ____________
Mucosa	☐	☐ ____________
Palate	☐	☐ ____________
Tongue	☐	☐ ____________
Floor	☐	☐ ____________
Glands	☐	☐ ____________
Pharynx	☐	☐ ____________

Upper Right	Upper Anterior	Upper Left
Lower Right	Lower Anterior	Lower Left

Maximum Pocket Depth Per Sextant in mm

Recall: ______ Months Doctor's Signature: Reviewed by: ____________

12651 West Sunrise blvd suite 200 sunrise, fl 33323. (954) 846-700. Fax(954) 846-0811

Credit Card Authorization Form for Credit Card on File

Name: ____

Address: ____

City: ____________________________ Zip Code: ____________________

Home Phone: ______________________ Work Phone: __________________

Cell Phone: ______________________ Email Address: ________________

Cardholder Name: _______________________________________

Credit Card Number: _____________________________________

Expiration Date: __________________ Security Code: ________________

I HEREBY AUTHORIZE Sawgrass Dental Center to charge my credit card for any broken appointment charges that may be incurred due to me not cancelling my scheduled appointment Within the 48 hour office policy. I understand that this policy is enforced and a copy of the credit card receipt will be mailed to me for any charges made.

Signature: ____________________________

Date of Authorization: __________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

B. PERMISSION TO USE INFORMATION

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. I give this office permission to use my health information to treat me as outlined on the back of this form.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

Please Note: Under current Florida Law we have the right to refuse to treat you if you do not sign this form. We will inform you if we choose that option.

YOUR NAME: ______________________________

DATE OF BIRTH: ______________________________

DRIVER'S LICENSE #: ______________________________

FORMS OF COMMUNICATION WITH OUR OFFICES

IN ORDER TO CONFIRM A FUTURE APPOINTMENT IN OUR OFFICES WHICH FORMS OF COMMUNICATION ***DO YOU PREFER:***

DO YOU PREFER A PHONE CALL? ______________________________

TO WHICH TELEPHONE NUMBER ? ______________________________

IS IT OK TO CALL YOUR WORK TEL NUMBER ? ______________________________

IS IT OK TO LEAVE A VOICE MESSAGE ON YOUR CELL PHONE ? ______________________________

IS IT OK TO SEND A TEXT MESSAGE TO YOUR CELL PHONE ? ______________________________

DO YOU AGREE WITH A FULL CONVERSATION WITH OUR OFFICES VIA TEXT MESSAGE ? ____________

DO YOU PREFER EMAIL ? ______________________________

PLEASE PROVIDE US WITH YOUR EMAIL______________________________

SIGNATURE : ______________________________

THANK YOU

DR. DIANA WOHLSTEIN DMD PLLC

Financial Policy

Thank you for choosing our practice to serve your dental needs.
Please take the time to read the following, initial each section, and sign and date the bottom of this form.

_______ Full payment is due at the time of service unless arrangements have been made prior to the start of any treatment.

_______ Insurance balances are ultimately the patient's obligation. We will file most primary insurances at no cost to you as a courtesy. However, insurance balances which are not paid within 60 days may be billed to you. Please keep your walk-out statements and follow up with your insurance carrier to ensure prompt payment.

_______ Some of your treatment may not be covered by your insurance carrier. The cost for such charges will be your responsibility.

_______ Major services may require a deposit equal to at least one half of the estimated patient portion at the time the appointment is made.

_______ Patients are asked to confirm their appointments at least 48 hours in advance by directly contacting our office or by responding to our confirmation contact. Failure to confirm your appointment may result in a charge for the time reserved.

_______ There will be a fee of $30.00 for any checks returned as Non-Sufficient Funds (NSF)

_______ Patient balances that go unpaid for 30 days or more may incur one or more of the following charges:

Interest charges of 1.5% per month
18% APR collections fees (up to 25% of the full balance)
Legal fees for collection services

________________________ ________________________
Signature of Patient or Guardian Date

________________________ ________________________
Print Name Witnessed By