

- 2. Import to Acrobat
- 3. Fill & Sign



Patient Information

Patient Name _____ Date of Birth _____ Soc. Sec.# _____

Address _____ City _____ State _____ Zip _____

E-mail _____ Sex: M / F

(circle one)

Minor Married Widowed Single Separated Divorced Partnered

Who Referred you to our office? _____

Phone Numbers

Home () _____ Cell Phone() _____ Work() _____ Ext _____

Spouses' work () _____ Best time to reach you? _____

IN CASE OF EMERGENCY CONTACT (SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD.)

Name _____ Relationship _____

Work # () _____ Cell#() _____

Who is responsible for this account? _____ Relationship to Patient _____

Phone () _____

DENTAL INSURANCE INFORMATION

Subscriber _____ Date of Birth _____ Soc. Sec. _____

Employer _____ Relationship to Pt _____

Insurance Company full Name _____ Group ID# _____

Patient ID # _____

ASSIGNMENT AND RELEASE

William J Fessler Family Dentistry requires payment at time of service. If you choose to discontinue care before treatment is complete, you will only be charged for care received and any lab fees incurred. We submit to insurance as a courtesy. Insurance is considered a method of reimbursing the patient for fees paid to the doctor, and is not a substitute for payment. It is your responsibility to pay any deductible, coinsurance, or any other balance not paid by your insurance at time of service. If our office is unable to collect payment from your carrier due to Insufficient subscriber information, or denial of benefits, the patient is responsible for balance on account. The patient and or responsible party agree to pay INTEREST at a rate of 1 1/2% per month and all costs of collection, including reasonable attorney fees, on all amounts due on account more than 30 days from the date of service. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I further hereby assign all dental benefits, to which I am entitled, including private insurance, and other health plans to William Fessler Family Dentistry. Assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. I further give permission to pull a credit report as needed, should my account be turned over to an outside source for a collection effort. A fee of \$65 is charged for patients who miss or cancel an appointment without 24 hours (business hours) notice. Current Bank fees for NSF checks will be billed to the patient for any returned checks.

(Responsible Party Signature: Patient, Guardian or Parent)

(Date)

HEALTH HISTORY

Physicians Name _____ Date of last visit _____

(Circle Yes or No to indicate if you have had any of the following)

Are taking Blood Thinners Yes No (if yes list) _____

Do you need to Pre-medicate Yes No (if yes reason) _____ (list antibiotic) _____

Have you taken Bisphosphonates (ie: for Osteoporosis) Yes No

AIDS/HIV	Yes No	Epilepsy	Yes No	Radiation Treatment	Yes No
Anemia	Yes No	Fainting of Dizziness	Yes No	Respiratory Disease	Yes No
Arthritis Rheumatism	Yes No	Glaucoma	Yes No	Rheumatic Fever	Yes No
Artificial Heart Valves	Yes No	Headaches	Yes No	Scarlet Fever	Yes No
Artificial Joints	Yes No	Heart Murmur	Yes No	Shortness of Breath	Yes No
Asthma	Yes No	Heart Problems	Yes No	Sinus Trouble	Yes No
Back Problems	Yes No	Hepatitis Type _____	Yes No	Skin Rash	Yes No
Excessive bleeding	Yes No	Herpes	Yes No	Special Diet	Yes No
Sudden weight loss	Yes No	High Blood Pressure	Yes No	Stroke	Yes No
Blood Disease	Yes No	Jaundice	Yes No	Swollen Feet or Ankles	Yes No
Cancer	Yes No	Jaw Pain	Yes No	Swollen Neck Glands	Yes No
Chemical Dependency	Yes No	Kidney Disease	Yes No	Thyroid Problems	Yes No
Chemotherapy	Yes No	Liver Disease	Yes No	Tonsillitis	Yes No
Circulatory Problems	Yes No	Low Blood Pressure	Yes No	Tuberculosis	Yes No
Congenital Heart Lesions	Yes No	Mitral Valve Prolapsed	Yes No	Tumor/growth on head	Yes No
Cough that's chronic	Yes No	Pacemaker	Yes No	Ulcer	Yes No
Diabetes	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Emphysema	Yes No				

Do you wear contact lenses? Yes No

Other conditions or if you answered Yes to above explain: _____

(Women)

Are you pregnant? Yes No Due Date _____ Nursing Yes no
 Taking Birth Control? Yes No

Medications

(List any medications and correlating diagnosis)

Allergies

(Circle all that apply)

Aspirin	Local Anesthetic
Barbiturates	Penicillin
Codeine	Sulfa
Iodine	Other _____
Latex	_____
No Known Allergies	

DENTAL HISTORY

Reason for today's visit:	Chew one side of mouth	Yes No	Mouth Breathing	Yes No
_____	Smoke Cigarette, pipe, cigars	Yes No	Mouth Pain, brushing	Yes No
_____	Clicking or popping jaw	Yes No	Orthodontic treatment	Yes No
Previous dentist:	Dry Mouth	Yes No	Pain around ear	Yes No
_____	Fingernail Biting	Yes No	Periodontal Treatment	Yes No
Address:	Food trapped between teeth	Yes No	Sensitivity to	HOT COLD
_____	Sensitivity to sweets	Yes No	Sensitivity biting	Yes No
_____	Grinding teeth	Yes No	Sores/Growths in mouth	Yes No
Bad Breath	Gums swollen tender	Yes No	Jaw Pain	Yes No
Bleeding Gums	Blisters on lips gums	Yes No	Lip/cheek biting	Yes No
Burning sensation on tongue	Loose teeth	Yes No	Broken filings	Yes No

How often do you floss? _____

How often do you brush? _____

Click **SUBMIT** button to send your completed form to our office. This button only works in Acrobat.

If you are having trouble, you can send the form in an email to: admin@wfesslerdds.com