WAY FAMILY DENTISTRY – PATIENT INFORMATION

Patient Name: _____ Date:_____
Last First MI

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone Home☐: _____ Work ☐: _____Cell☐: _____

(please check the best no. you would like us to use to confirm appointments)

Address: _____
Street Apartment #

_____
City State Zip

Email Address: _____

Medical History

Have you ever had any of the following? Please check those that apply:

- ☐ AIDS/HIV
- ☐ Allergies (seasonal)
  Other _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
  - ☐ Heart Murmur
  - ☐ Premed?_____
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ **Pregnant (currently)**
  Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Codeine Allergy
- ☐ Penicillin Allergy
- ☐ Latex allergy
- ☐ Sulfa allergy

OTHER Conditions Not listed:

- ☐ _____
- ☐ _____

☐ **Premed**
ie: joint replacement

- Name of Physician: _____ Phone:_____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:_____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:_____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:_____

Date of last Dental Cleaning: _____ Reason for the Dental visit _____

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:_____

Do /did you use Alcohol Yes/ No If Yes describe _____

Do /Did you chew/smoke tobacco ? Yes/ No If yes how many _____

Do /did you use recreational drugs ? Yes / No If yes describe _____

- Medications you are taking? _____

_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Internet ☐ Newspaper ☐ Insurance Co. ☐ Work ☐ Other_____

Name of person of office referring you to our practice: _____

Employment Information

Employer Name: _____ Occupation:_____ Phone #_____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Insurance Plan Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Name of Subscriber: _____
Last First M

Subscriber's Birth Date: _____ SS/ID #: _____ Group #:_____

Subscriber's Address: _____
Street City State Zip Code

Subscriber's Employer Name:_____ Phone: _____

Address: _____
Street City State Zip Code

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date:_____
Signature of patient, parent or guardian

Consent for Services

I give permission for Dr Jorge Way to perform dental services for myself and my family.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.
A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to email me or to telephone me at home, cellular phone or at my work to discuss matters related to this form or treatment.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

CONTACT INFORMATION or INSURANCE or MEDICAL HISTORY UPDATES

Changes in Medical History? Yes No **Changes in Dental Insurance? Yes No**
(If yes please explain below)

(Patient Signature) (Date) (Staff Initials)

Changes in Medical History? Yes No **Changes in Dental Insurance? Yes No**
(If yes please explain below)

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