Welcome to Wyoming Cosmetic and Family Dental
Jason N. Whiting, DMD

PATIENT INFORMATION

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT OR PARENT'S EMPLOYER _____

CITY _____ STATE _____ ZIP _____

IF PT IS A STUDENT, NAME OF SCHOOL _____

CITY _____ STATE _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

_____

CONFIDENTIAL

BIRTHDATE _____

SOCIAL SECURITY #_____

CELL PHONE _____

EMAIL:_____

_____

CIRCLE APPROPRIATE SELECTION:

MINOR SINGLE MARRIED

HOME PHONE _____

CELL PHONE _____

WORK PHONE_____

INSURANCE SUBSCRIBER INFO

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT _____

_____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

EMPLOYER _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

HOME PHONE _____

WORK PHONE _____

CELL PHONE _____

BIRTHDATE _____

SS NUMBER _____

INSURANCE INFORMATION

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PATIENT NAME _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

ADDITIONAL INSURANCE

NAME OF INSURED _____

INSURANCE COMPANY _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

BIRTHDATE _____

SS NUMBER _____

GROUP NUMBER _____

INSURANCE PHONE _____

PATIENT MEDICAL HISTORY

PHYSICIAN NAME _____

PHYSICIAN PHONE _____

EMERGENCY CONTACT:_____

EMERGENCY CONTACT PHONE NUMBER:_____

DATE OF LAST EXAM _____

- ARE YOU UNDER THE CARE OF A PHYSICIAN YES NO
- HAVE YOU BEEN HOSPITALIZED IN THE LAST FIVE YEARS YES NO
- ARE YOU TAKING MEDICATIONS? INCLUDING OVER THE COUNTER AND PRESCRIPTION YES NO

please list: _____

- DO YOU USE TOBACCO? YES NO
- DO YOU USE ALCOHOL? YES NO
- DO YOU USE COCAINE OR OTHER DRUGS? YES NO
- DO YOU WEAR CONTACTS? YES NO
- DO YOU HAVE ANY ALLERGIES? (please list) YES NO

  _____
- HAVE YOU EVER HAD A REACTION TO ANESTHETIC? YES NO

WOMEN ONLY:

- ARE YOU PREGNANT _____
- ARE YOU NURSING _____
- ARE YOU TAKING BIRTH CONTROL PILLS _____

Please list all medications you are taking including :

_____

_____

PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS ABOUT YOURSELF: (*MARK ALL ANSWERS WITH A YES OR NO)*

	YES	NO		YES	NO		YES	NO
HIGH BLOOD PRESSURE	___	___	FREQUENTLY TIRED	___	___	KIDNEY DISEASE	___	___
HEART ATTACK	___	___	ANEMIA	___	___	AIDS/HIV INFECTION	___	___
RHEUMATIC FEVER	___	___	EMPHYSEMA	___	___	STD'S	___	___
SWOLLEN ANKLES	___	___	CANCER	___	___	THYROID PROBLEMS	___	___
FAINTING/SEIZURES	___	___	ARTHRITIS	___	___	HEPATITIS A, B OR C	___	___
ASTHMA	___	___	JOINT REPLACEMENT	___	___	ULCERS	___	___
LOW BLOOD PRESSURE	___	___	CHEST PAINS	___	___	RESPIRATORY PROBLEMS	___	___
EPILEPSY/CONVULSIONS	___	___	SHORT OF BREATH	___	___	OTHER _____		
LEUKEMIA	___	___	STROKE	___	___	_____		
DIABETES	___	___	HAY FEVER/ALLERGIES	___	___	_____		
HEART DISEASE	___	___	TUBERCULOSIS	___	___	_____		
CARDIAC PACE MAKER	___	___	RADIATION THERAPY	___	___	_____		
HEART MURMER	___	___	GLAUCOMA	___	___	_____		
ANGINA	___	___	LIVER DISEASE	___	___			

PATIENT DENTAL HISTORY

I certify that I have read and understand the above information. To the best of my knowledge, the above questions have been answered accurately. I understand that providing false or incorrect information can be dangerous to my health. _____ _____ PATIENT SIGNATURE DATE _____ PRINT NAME	_____ DENTIST SIGNATURE _____ DATE _____ WITNESS SIGNATURE _____ DATE

The following Financial Policy is required prior to any dental treatment. Please understand we do not want to see financial constraints and/or broken appointments interfere with dental care and the doctor/patient relationship. To facilitate your payments, the following options are listed. Please read them carefully, initial and sign all designated lines.

Payment:

A 20% down payment will be required to schedule all treatment appointments and is non- refundable_____(initial)

Payment must be rendered before services will be performed on each date of service._____ (Initial) Failure to pay will result in an immediate reschedule of your appointment. This policy is strictly enforced.

Payment Options

IF YOU HAVE INSURANCE, We will submit your insurance claim to your insurance carrier as a courtesy to you. The amount of coverage paid by your insurance company may be based on your insurance company's Usual and Customary Rates and/or Fee Schedule. You are responsible at the time of your appointment for any deductible or co-payment not covered by the insurance company, as well as any remaining balance that the insurance company fails to pay. If your insurance company does not remit payment within 60 days, the balance will be due from you and may be subject to service charges._____ (Initial)

BROKEN APPOINTMENT POLICY Appointments in our office are reserved exclusively for each patient and are also customized according to individual needs. For this reason, if you are unable to keep your reserved appointment, please give us at least 48 hours notice. If you have a Monday appointment and need to cancel or reschedule, you need to contact our office no later than Thursday the week before. We charge $75.00 for all broken appointments, no shows, and rescheduled appointments if less than 48 hours notice is not given. _____ (Initial)

If a second broken appointment occurs, we will NOT reschedule your appointment at that time, instead we will place you on a short-notice list and we will call you when we have an appointment time available. In addition, you will also be required to PRE-PAY for your next appointment in FULL, as well as any broken appointment fee(s)._____ (Initial) In the event you break an appointment for the 3rd time, we will NOT reschedule your appointment. We will provide 30 days emergency care, to allow you time to find another dental provider. _____ (Initial)

ADDITIONAL COSTS

I understand and agree to pay for ALL cost involved with a collection agency, small claims court and/or an attorney's fees if my account is not paid in full. _____ (Initial)

RETURNED CHECKS

There will be a $35.00 returned check fee applied to your account if a check is returned. The account then must be paid by Cash, MasterCard, or Visa. _____ (Initial)

Minor Children (under the age of 18) must be accompanied by a parent/guardian for the full duration of their appointment. _____ (Initial)

Signature of Responsible Party: _____ Date: _____

Consent to Disclose Personal Health Information

Help us communicate with you better.

Please use this form to tell us when you would like us to discuss your health with others, and how we should contact you with non-urgent news such as appointment reminders. If you are completing this form on behalf of another patient (i.e. minor child), please use the patient's information

1. **What name I prefer to be called: _____**
2. **How I like *routine* messages**
   Email:_____
   Cell Phone:_____ Work:_____ HM:_____

3. **Where is it okay to leave messages about my health:**
   At home At Work Mobile number Email

4. **Who is it okay to discuss my health with:**
   ☐ No one
   ☐ Any of the people listed below:

   _____

   _____

   _____

5. **What is okay to discuss or leave a message about:**

___ **Any** information about my treatment and account*, **OR:**
___ Appointment Information ___Prescription drug information ____Release of Records
___ Post-op instructions ____Account balance ____Needed treatment only
____ Other (specify):_____

*This may include detailed personal medical information including dental services to be provided, notification that items such as lab cases are ready, as well as any information listed in #5 above.

_____ _____
Patient's Name **Date**

_____
Signature of Patient or Guardian/Parent

This consent will remain in effect until revoked by the patient/parent/guardian, or in the case of minor, on the date the minor becomes an adult under the state law. Please advise us of any changes to your preference

Wyoming Cosmetic & Family Dental Privacy Notice

This notice describes how medical/ Dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your Dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at 307-635-2419

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other Dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information and any information you provide. During the course of your treatment we will collect Dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your information to other Dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Wyoming Cosmetic & Family Dental does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment.

Safeguarding Your Personal and Health Information

We are required by law to (1) make sure that medical information that identifies you is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Wyoming Cosmetic & Family Dental maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Wyoming Cosmetic & Family Dental.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Wyoming Cosmetic & Family Dental occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient Acknowledgement

I_____ have reviewed Wyoming Cosmetic & Family Dental Privacy Policy.

Signed_____ Date_____