Artistic Dentistry

The Best Friend Your Teeth Have Ever Had

PATIENT FULL NAME:

Mailing Address: _____

City:_____ **State**: _____ **Zip**:_____

P.O. BOX _____State_____zip_____

Home Phone: _____**Work Phone:**_____**Cell Phone**:_____

SSN# _____**Date of Birth:** _____**Driver's License #**: _____

Email for appointment reminders: _____

INSURED PARTY NAME

Home Number: _____ **Cell**:_____

Date of Birth: _____**SSN#** _____**Driver's License #**: _____

Emergency Contact: _____ **Relationship:** _____ **Telephone #:**_____

MEDICAL HEALTH HISTORY:

Name of Physician: _____ Telephone: _____

List Medications you are currently taking and its purpose:

Has your physician ever indicated you need antibiotic pre-medication prior to dental treatement: **Yes No**

Have you ever been treated for the following? (Please Circle One)

Hip or Joint Replacement	**Yes No**	Ulcers	**Yes No**	
Rheumatic Fever	**Yes No**	Diabetes	**Yes No**	
Abnormal Blood Pressure	**Yes No**	Jaundice	**Yes No**	
Tuberculosis Heart Disease	**Yes No**	HIV/ AIDS	**Yes No**	
Asthma or Hay Fever	**Yes No**	Epilepsy	**Yes No**	
Sinus Trouble	**Yes No**	Anemia	**Yes No**	
Mitro Valve Prolapse	**Yes No**	Hepatitis	**Yes No**	
Arthritis	**Yes No**	Pregnant	**Yes No**	**How Far**
Heart Murmur	**Yes No**	Cancer	**Yes No**	
Prolonged Bleeding	**Yes No**	Stroke	**Yes No**	
Fainting Spells	**Yes No**	OTHER:		

Tobacco Use **Yes No ** Would you like tobacco councelling?**_____

CHECK IF YOU ARE ALLERGIC TO:

Codeine___ Penicillin___ Local Injected Anesthetic___ Other: _____

Difficulty getting numb ? yes no

I have read and answered the above questions to the best of my knowledge. I authorize and request my insurance company to pay all insurance benefits to Dr. Wasselle and authorize the use of my signature on all submissions. I authorize the doctor to release all information necessary to secure payment. I understand that insurance is billed on my behalf as a courtesy and I am ultimately responsible for my account. My copayment due at time of service is an **ESTIMATE** based of information obtain from my insurance company and in no way guarantees payment from them. Any claim or balance unpaid over 90 days from date of service is immediately due from the responsible party regardless of insurance status. In the event that any treatment involving crown, bridge, or denture appliance being made on my behalf; if treatment is not completed (appliance delivered to me) within six months from prep date, I will pay the entire fee regardless of my insurance status. *(Most insurance companies pay dental claims for crowns, bridges, and dentures only after the appliance is delivered to the patient).

Sign _____ Date

Artistic Dentistry Office Policies

Financial Policy

Treatment cost estimates are provided to you, the patient, prior to treatment. We do file insurance claims on your behalf; however, your copayment is due at time of service. Although we fille insurance claims for you, the ultimate responsibility f your bill is you. If after 60 days, no payment is received from your insurance compnay, payment in fill is due from you. All accounts over 90 days will be subject to an 18% per annual finance charge. Accounts unpaid after 120 days are sent for collections.

Initial and date: _____

Cancellation Policy:

I understand a $45 fee will be assessed to my account should I fail an appointment without 2 business days notice. **Initial and date:** _____

Acknowledgement of Receipt of HIPPA compliance:

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 (HIPPA). **Initial and date:** _____

Prosthetic Policy:

In the event that any treatment involving crown, bridge, partial, or denture appliance being made on my behalf; if treatment is not completed (appliance delivered to me) within three months from prep date, I will be responsible for the entire fee regardless of my insurance status. *(Most insurance companies pay dental claims for crowns, bridges, and dentures only after the appliance is delivered to the patient).

Initial and date: _____

Local Anesthetics

The local anesthetic I am receiving may contain epinephrine that can cause a slight increase in heart rate which will return to normal. Common complications that can occur from local anesthetic include but are not limited to pain, swelling, and bruising. Rare serious complications may occur that can include but are not limited to permanent numbness, abnormal sensation, transient blindness.

Initial and date: _____

Changes in Treatment Plan

I understand that during treatment it may be necessary to change or add procedures due to condition found while working on the teeth that were not discovered during the inital examination. I give permission to Dr. Wasselle to make any/ all changes and additions necessary once I have been informed of these changes and consented to them. I also understand that not following my dentist's recommendation or delaying treatment may lead to but not limited to discomfort, increased complexity of the treatment outcome, and even loss of teeth.

Initial and date: _____

Patient Signature: _____ **Date:**_____