USE BLACK OR BLUE INK ONLY

PATIENT REGISTRATION

SECTION 1: PATIENT DATA

Last Name _____ First Name _____ MI _____

☐ Male ☐ Single
☐ Female ☐ Married

Name of Spouse _____

Address _____City _____ State _____ Zip _____

Patient's Home Phone _____ Work Phone _____ Cell Phone _____

Employer or School if Student _____ Patient Date of Birth _____

Patient's Social Security # _____ Driver's License #_____ E-Mail _____

Who referred you to our office? _____

Emergency Contact _____Phone_____Relationship_____

Secondary Contact _____Phone_____Relationship_____

SECTION 2: RESPONSIBLE PARTY INFORMATION (If you are not the patient)

Last Name _____ First Name _____ MI _____ Title: _____ Mr. _____ Mrs. _____ Ms.

Address _____ City _____ State _____ Zip _____

Responsible Party's Home Phone_____ Work _____ Cell _____

Responsible Party's Birth Date _____ Social Security # _____ Driver's License # _____

Responsible Party's Employer _____

SECTION 3: PRIMARY INSURANCE INFORMATION:

Name of Insured _____ Relationship to Patient _____ Birth Date of Insured _____

Social Security Number of Insured _____ Employer's Name_____

Insurance Company _____Group Number _____

SECTION 4: SECONDARY INSURANCE INFORMATION:

Name of Insured _____ Relationship to Patient _____ Birth Date of Insured _____

Social Security Number of Insured _____ Employer's Name_____

Insurance Company _____ Group Number_____

SECTION 5: AUTHORIZATION AND RELEASE:

I authorize and request my insurance company to pay directly to the dentist insurance benefit otherwise payable to me. I authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

>SIGNATURE OF PATIENT OR PARENT IF MINOR_____ DATE _____

SECTION 6: FINANCIAL RESPONSIBILITY:

I understand that dental insurance is a contract between myself and my insurance company. I further understand and agree that I am financially responsible for all legal charges whether or not paid by insurance. I also understand that if collection procedures become necessary, I am responsible for any and all legal charges incurred by the dentist to collect charges due by me.

>SIGNATURE OF RESPONSIBLE PARTY _____DATE _____

Patient Medical History

Patient Name _____ Birth date _____
Physician _____ Office phone _____ Date of Last Exam_____

Are you under the care of a physician now? Yes No If yes, explain: _____
Have you recently been hospitalized? Yes No If yes, explain: _____
Are you taking any medications, pills, or drugs, prescription and non-prescription? Yes No Please list: _____
Do you take or have you taken Phen-Fen or Redux? Yes No _____
Have you taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____
Do you or have you used tobacco? Yes No _____
Do you use controlled substances? Yes No _____
Have you ever been told you need antibiotic premed prior to dental treatment? Yes No _____

Women, are you?
Pregnant/Trying to get pregnant: Yes No Taking oral contraceptives: Yes No Nursing: Yes No

Are you allergic to any of the following:
Aspirin Penicillin Codeine Local Anesthesia Acrylic Metal Latex Sulfa drugs
Other: Please explain: _____

Do you have *or* have you had any of the following? (Circle Y OR N)

Acid Reflux	Y N	Cancer	Y N	Heart Pacemaker	Y N	Lung Disease	Y N
AIDS/HIV	Y N	Chemotherapy	Y N	Heart Trouble	Y N	Mitral Valve Prolapse	Y N
Alzheimer's	Y N	Cold Sores	Y N	Hepatitis A	Y N	Osteoporosis	Y N
Anaphylaxis	Y N	Diabetes	Y N	Hemophilia	Y N	Psychiatric Care	Y N
Anemia	Y N	Drug Addiction	Y N	Hepatitis B or C	Y N	Radiation	Y N
Angina	Y N	Emphysema	Y N	Herpes	Y N	Renal Dialysis	Y N
Arthritis	Y N	Epilepsy/Seizures	Y N	High Blood Pressure	Y N	Rheumatic Fever	Y N
Artificial Joints	Y N	Excessive Bleeding	Y N	High Cholesterol	Y N	Shingles	Y N
Asthma	Y N	Fainting/Dizziness	Y N	Hives or Rash	Y N	Sinus Trouble	Y N
Autoimmune	Y N	Frequent Headaches	Y N	Hypoglycemia	Y N	Stroke	Y N
Blood Disease	Y N	Glaucoma	Y N	Irregular Heartbeat	Y N	Thyroid Disease	Y N
Blood Transfusion	Y N	Hay Fever/Allergies	Y N	Kidney Problems	Y N	Tonsillitis	Y N
Breathing Problem	Y N	Heart Attack/Disease	Y N	Liver Disease	Y N	Tumors or Growths	Y N
Bruise Easily	Y N	Heart Murmur	Y N	Low Blood Pressure	Y N	Ulcers	Y N

Patient Dental History: Date of last dental exam: _____ Date of last cleaning: _____

Do you like your smile? Y N
Do any of your teeth hurt? Y N
Do your gums bleed while brushing or flossing? Y N
Are your teeth sensitive to hot/cold foods or liquids? Y N
Are your teeth sensitive to sweet/sour foods? Y N
Do you have any sores or lumps in your mouth? Y N
Do you have history of any periodontal therapy? Y N
Have you had orthodontic treatment? Y N
Do you snore or been told you snore? Y N
Have you had any head, neck or jaw injuries? Y N
Do you bite your lips or cheeks frequently? Y N

Have you ever had any prolonged bleeding following extractions? Y N
Do you wear dentures or partials? Y N
If yes, date of placement_____
Do you clench or grind your teeth? Y N
Have you ever experienced any of the following in your jaw?
- Clicking or popping Y N
- Pain Y N
- Difficulty in opening or closing Y N
- Difficulty in chewing Y N

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____ **Date**_____
Signature of Dentist_____ Date _____

Consent Form – Oral Cancer Screening

Our office strives to bring its patients state-of-the-art technology to provide you with the latest advancements in oral health. We have recently introduced the OralID screening device into our office. The OralID examination will aid in visualization of oral mucosal abnormalities, such as cancer and pre-cancer. The procedure is quick, painless and no rinses or dyes are used.

Similar to other cancers, early detection of oral cancer is critical. If oral cancer is detected in its later stages, which typically only occurs during a conventional oral cancer exam, the chances of survival are dramatically reduced.

Who is at Risk?

- Age - 17+ years
- Tobacco Use
- Alcohol Use
- HPV infection
- Previous history of cancer

If you have any questions about risk factors, please feel free to talk to our hygiene staff. We recommend all of our patients be screened with the OralID.

Our office charges $20 per screening with the OralID. We will attempt to bill your insurance, but you will be responsible for any unpaid amount or denial by your insurance company.

☐ Yes, I request that your staff perform an examination with the OralID. I accept financial responsibility for this examination.

_____

Patient Signature Date

☐ No, I prefer to not have this examination.

_____

Patient Signature Date

Dr. Wesley Wermuth, DDS ~ 510 SE 1st Street ~ Mineral Wells, TX 76067

940-328-1131

INFORMED CONSENT FOR XRAYS, EXAM AND CLEANING

This form is intended to provide you with an overview of potential risks and complications associated with regular dental care. It is important that you follow your dentist's recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled follow up appointments. Please read the items below and sign at the bottom of the form.

1. EXAMINATIONS AND X-RAYS: I understand that radiographs are required for examination and diagnosis or my oral health. A periodic examination will be provided by the dentist at routine cleanings to evaluate your mouth for decay, gum disease, root pathology, oral cancer and overall health. This office follows the guidelines of the American Dental Association and recommends that FULL MOUTH XRAYS (FMX) and a PANO BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITE WING XRAYS every year. Though dental x-ray exposure is minimal, every effort to reduce exposure has been taken with the use of a lead apron and thyroid collar. **Pregnant Women**: XRAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform this office staff if you think you are pregnant and x-rays will be postponed. (Initials_____

2. TEMPRO-MANDIBULAR JOINT DYSFUNCTION (TMD): I understand that popping, clicking, locking and pain can intensify or develop in the jaw joint during or following routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually temporary, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials_____)

3. CHANGES IN TREATMENT PLAN: I understand that during treatment, it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. (Initials_____)

4. DENTAL PROPHYLAXIS (regular cleaning): I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums. It is limited to the removal of plaque, light tarter and stain from the tooth structures *above the gum margins* and in the absence of periodontal (gum) disease. This treatment prevents gingivitis and gum disease. Some light bleeding, gum soreness, sensitivity and/or cold sores after a cleaning may occur. (Initials_____)

OR

PERIODONTAL MAINTENANCE: These procedures are to clean and/or aid in rehabilitation of the gums, teeth and underlying bony structures. Periodontal disease is often chronic and asymptomatic. Upon completion of, or during these procedures, I may have sensitive gums or teeth, often for a few hours to several days after these procedures. Occasionally, soft tissue or gum swelling may occur. Should any of these conditions arise and not subside within a few days of these procedures, I will contact my treating dentist. (Initials_____)

I have read each paragraph above and consent to recommended treatment.

_____

Patient Signature Date

FOUR SEASONS DENTAL

MISSED & LATE APPOINTMENT POLICY

Dr. Wesley and staff strive to accommodate all patients' dental needs. In doing so, we schedule the appointments at the time and day requested by the patient. We work on a very close schedule and try to stay on time to eliminate long wait times. In order to stay on schedule, it is very important that the patient is on time for the appointment so the next patient does not experience delays. In respecting your time, we also ask that you respect our time that we have set aside exclusively for your appointment. To be courteous to *all* of our patients, we have set some guidelines in place as follows:

For patients who are 5 minutes late or later, we:

- May be able to accommodate
- May have to alter treatment
- May have to re-schedule the appointment (which will also disqualify "Teeth Whitening For Life" patients)

- Patients who miss the *first scheduled appointment* with an acceptable excuse will be allowed to reschedule.

- Patients who miss the *second scheduled appointment* will be reappointed with payment of a $50 non-refundable deposit. That deposit will be applied to the appointment if the patient is present for that scheduled appointment, otherwise, forfeited.

- Patients who miss the *third scheduled appointment* may be dismissed from the practice. This is definitely not our choice of action.

I have received and understand Four Seasons Dental policies concerning late and missed appointments.

_____

Patient Signature Date

Dr. Wesley Wermuth, DDS ~ 510 SE 1st Street ~ Mineral Wells, TX 76067

940-328-1131

PATIENT FINANCIAL AGREEMENT FOR THE OFFICE OF

FOUR SEASONS DENTAL

This agreement is to inform you of your financial obligation to our practice. We are committed to providing you with the highest quality dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. This financial agreement is intended to facilitate excellent service to you while minimizing our administrative costs.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claim, you must bring a completed dental insurance form or proof of insurance at each appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, and Discover. Outside financing is available through Care Credit upon request and approval.

Returned checks are subject to collection fees equal to the amount charge to us by the bank plus the amount of the returned check. Balances older than 60 days are subject to be sent to American Credit Bureau.

If your account becomes past due, our office will take all necessary steps to collect the debt. If your account has to be referred to a collection agency or requires the services of a lawyer and court fees, you will be charged all the collection fees, lawyer fees, and court cost that are incurred. In case of suit, the venue shall be in Mineral Wells, Texas and Palo Pinto County.

If you have questions regarding this financial agreement, please ask. We are committed to providing you with the most experience in dental care.

_____

Print Name Date

_____

Patient Signature Date

_____

Authorized Guardian Date

_____

Doctor Signature Date

_____

Witness Date

CONSENT FOR USE AND DISCLOSURE OF

HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Phone number: _____ Email:_____

Date of Birth: _____

SECTION B: TO THE PATIENT- PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of privacy practice: You have the right to read our Notice of Privacy Practice before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practice, we will issue a revised Notice of Privacy Practice, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practice, including any revisions of our notice, at anytime by contacting:

Contact Person:	Dr. Wesley Wermuth
Phone:	940-328-1131 Fax: 940-328-1135
E-mail:	4sd@suddenlinkmail.com
Address:	510 SE 1st Street, Mineral Wells, TX 76067

Right to revoke: You will have the right to revoke this consent at anytime by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on the consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, _____ , have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to use and disclose protected health information to carry out treatment, payment activities and healthcare operations.

I am placing the following restrictions on this consent: _____

Signature: _____ **Date**: _____

If a personal representative on behalf of the patient is signing this consent, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's chart