DENTAL & MEDICAL SPA
WINDERMERE

Welcome to Our Office!

To help us meet all your healthcare needs, please fill out this form completely. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information (Confidential)

Name _____ Date _____

Soc. Sec. # _____ Birthdate_____ Age _____ Sex _____

Cell #_____ Home # _____ Email _____

Address_____ City_____ State _____ Zip _____

Emergency Contact _____ Relationship _____ Phone_____

When confirming appointments how do you prefer to be contacted? ❑Phone ❑Email ❑Text Message

Approval to leave a message? □ No □ Yes

How did you hear about our office? (Check All That Apply)

❑Mail ❑Google ❑Website ❑Flyer ❑Drive By ❑Brochure ❑Friend or Patient _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ Social Security# _____

Name of Employer _____ Insurance Company _____

Group #_____ Policy/ID_____

Ins. Co. Address _____ City_____ State____ Zip_____

Patient Medical History

Primary Care Physician _____ Office Phone_____

1.Are you under medical treatment now? NO/YES, please explain_____

_____

2. Have you ever been hospitalized for any surgical operations (including plastic surgery) or serious illnesses within the last 5 years? NO/YES, please explain _____

3. Are you taking any medication(s) including non-prescription medicine? NO/YES, if so please list what medications are you taking? _____

4. Do you use Tobacco? NO/YES 6. Do you use controlled substances or recreational drugs? NO/YES

5. Are You **Allergic** to any medications? NO/YES, please explain _____

6. Have you ever had a reaction to any of the following?

❑Local anesthetics
❑Antibiotics
❑Sulfa drugs
❑Barbiturates or sleeping pills
❑Aspirin, Acetaminophen, or Ibuprofen
❑Codeine, Demerol, or other narcotics
❑Reaction to metals
❑Latex or Rubber
❑Other_____
_____

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7. Do you have, or have you had any of the following? (Please check all that apply)

❑Heart problems
❑Chest pain
❑Blood pressure problems
❑Heart murmur
❑Rheumatic fever
❑Pacemaker
❑Artificial heart valve
❑Bruises easily
❑Frequent nosebleeds
❑Anemia
❑Allergy problems
❑Hormone imbalance
❑Sinus problems
❑Skin rashes
❑Asthma

❑Intestinal Problems
❑Ulcers
❑Weight gain/loss
❑Constipation/ Diarrhea
❑Kidney or bladder problems
❑Arthritis
❑Back or neck pain
❑Any active infection
❑Joint replacement _____ ❑ Fainting, seizures or epilepsy
❑Stroke
❑Headaches/ Migraines

❑Thyroid problems
❑Persistent cough or swollen glands
❑Cancer/ Tumor
❑Diabetes
❑Tuberculosis
❑Hepatitis, jaundice, or liver trouble
❑Herpes virus
❑STD _____
❑HIV-positive/ AIDS
❑Glaucoma
❑Seizure disorder
❑History of head injury
❑Epilepsy or other neurological disease

❑Psychological treatment
❑Vitiligo
❑Auto-immune disease
❑Skin diseases/skin cancer _____(type)
❑Keloid scarring
❑Alcoholism
❑MRSA
❑Other_____ _____

Women Only:

a) Are you pregnant? NO/YES, _____weeks

b) Are you taking contraceptives or hormones? NO/YES, _____

c) Are you Nursing? NO/YES

d) Have you reached Menopause? NO/YES, if so are you having symptoms? _____

Authorization and Release: I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners.

Patient/Guardian signature _____ Date _____

Print name _____ Relationship _____

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Financial Policy

As a patient of Windermere Dental & Medical Spa, you understand that you are responsible to pay for services and treatment provided by our office. We require that you pay your portion on the day services are rendered. If you would like to put your balance on your credit or debit card, we accept the following: VISA, MasterCard, Discover & American Express. We are happy to offer a flexible financing option through: Care Credit. For uninsured patients we offer our Dental Savings Plan.

You also understand that even if an estimate is given or a procedure has been pre-approved you are responsible for any costs that your insurance company does not cover.

To accommodate our patient's time and busy schedule, we schedule exclusive appointments for each patient and always strive to stay on time. We sincerely ask that our patients respect this policy and provide us with at least 48 hours' notice if you are unable to keep the time we have reserved for your dental care. Appointments broken with less than 48 hours' notice will be charge a cancellation fee of $50.

Initial:_____

Insurance Policy

You are fortunate to have dental insurance, whether you have purchased it or your employer has provided it for you. Though your dental insurance is your responsibility we can help! We will go the extra mile to help you maximize your benefits. As a courtesy, we will help by filing your insurance forms, which will save you considerable time and trouble. We accept payments from most insurance companies, which reduces your immediate out-of-pocket expense.

Regardless of what we may calculate your insurance company to pay, it is only an estimate. Our estimate is based on limited information obtained from your insurance company. You must understand, we cannot forecast what they will pay. Should your coverage be less than anticipated, you will be responsible for the difference.
We must stress that you are responsible for the total treatment fee. Your dental insurance is not designed to pay the entire cost of your treatment, but it is intended to help cover a certain portion of the cost. Better terms for dental insurance may be "dental assistance" or "dental benefits."

Initial:_____

Radiographic Consent

I, _____, agree to a radiographic and clinical examination. I also understand and consent to the following:

1. During my treatment, I may undergo procedures in all phases of dentistry including periodontics (gum treatment and surgery), oral surgery, endodontics (root canals), fixed and removable prosthodontics (crowns, bridges, and dentures), implant dentistry, restorative dentistry, temporomandibular disorder treatment, sleep apnea treatment, oral pathology, pediatric dentistry, and radiography.
2. No guarantees can be made about treatment outcomes, restoration longevity, or prognoses. I understand that any branch of medicine, including dentistry, can involve unanticipated results.
4. My treatment plan may change at any time and I will do my best to approach my dental care with optimism and open communication with my dentist, hygienist, and dental office staff.
5. I am welcome to ask questions about any aspects of my dental care and will request information if I am confused or need more information. I am responsible for clarifying any aspects of my treatment that I am unsure about.

Initial:_____

By signing below, I agree that I am fully responsible for the total payment of all procedures performed in this office. I understand that my portion for services is due in full at the time of service unless other financial arrangements have been signed. Any portions billed to my insurance are to be paid in full within 90 days from the date of service, regardless of whether or not my insurance has provided reimbursement or allow the submitted charges. Any balance not paid in full within 90 days will accumulate a charge of 10% per month and I will be responsible for my balance, all finance fees, all collection agency fees, and any additional costs associated with collecting the full balance on my account.

Print name _____

Relationship_____

Patient/Guardian signature_____

Date _____