Patient Information Sheet

Dr. Christiaan A. Willig, DDS

Dr. Jennyfer Delvasto, DDS

Dr. Abe Saff, DDS

Please turn off cell phones. Thank you.

Date:_____

Patient Legal Name:_____ Preferred Name:_____
Last First MI

Street Address:_____Apt.#_____

City:_____State:_____ Zip code:_____

Sex: M F Marital Status: M S Birth Date: _____Social Security(required)#:_____

Ph (Home):_____ Ph (Work):_____ Ext: ___ Cell: _____

Employer/School: _____Best time to call:_____ Email:_____

Nearest relative not living with you: (Name)_____ Phone #:_____

Insurance Information

Subscriber Name: _____ SS#: _____ Birth Date:_____

Dental Insurance Company: _____ID#_____

Employer:_____Phone: _____

Responsible Party

(Parents or guardian)

Name:_____ Relationship: _____ Birth Date: _____

S.S. #:_____Ph (Home): _____ Ph (Work): _____

Name:_____ Relationship: _____ Birth Date: _____

S.S. #:_____Ph (Home): _____ Ph (Work): _____

Referral Information

Yellow Page Ad____ Newspaper___ Drive-by___ Website___ Facebook___ Insurance___

Another Dental office___ Another Patient (Name):_____

Medical History for _____**(patient name)**

Do you have a personal Physician? Y N
Are you currently under a physician's care? Y N
If so, why? _____

Physician's Name: _____
Phone #_____ Date of Last Visit:_____

Your Current Physical Health is:
Good Fair Poor
Do you smoke or use tobacco in any form? Y N
Do you have any implants, valves, rods, or pins? Y N
Are you taking any medications? Please List:

_____

_____

Have you been hospitalized or had a serious illness or surgery in the past three years? Y N
If yes, why? _____

_____

Have you ever taken Phen-Fen, Redux or Pondimin? (Diet pills) Y N
If yes, when? _____
Have you ever taken Fosamax? Y N
If yes, when? _____

For Women:
Are you taking birth control pills? Y N
Are you pregnant? Y N
Due Date: _____
Are you Nursing? Y N

Allergies:
Are you allergic to any of the following? (Please circle)

Aspirin	Sulfa Drugs
Codeine	Iodine
Dental Anesthetics	Jewelry/Metals
Erythromycin	Tetracycline
Latex	Other:_____

Have you ever had any of the following medical conditions? (Answer all that apply)

Y	N	Alcohol/Drug Abuse	Y	N	Heart Murmur
Y	N	Anemia	Y	N	Heart Surgery
Y	N	Arthritis	Y	N	Hemophilia
Y	N	Artificial Joints/Valves	Y	N	Hepatitis (A,B,C,D,E)
Y	N	Asthma	Y	N	High Blood Pressure
Y	N	Autism	Y	N	HIV/AIDS
Y	N	Blood Disease	Y	N	Kidney Disease
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Bruise Easily	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Migraine Headaches
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Deaf	Y	N	Organ Transplant
Y	N	Dentures/Partials	Y	N	Pace Maker
Y	N	Diabetes-Type1,Type 2	Y	N	Psychiatric disorder
Y	N	Difficulty Breathing	Y	N	Radiation Therapy
Y	N	Dry Mouth	Y	N	Respiratory Problems
Y	N	Eating Disorder	Y	N	Rheumatic Fever
Y	N	Emphysema	Y	N	Seizures
Y	N	Epilepsy	Y	N	Sickle Cell Trait
Y	N	Excessive Bleeding	Y	N	Sinus Problems
Y	N	Fainting/Dizzy Spells	Y	N	STD
Y	N	Frequent Headaches	Y	N	Steroid Treatment
Y	N	Glaucoma	Y	N	Stroke
Y	N	Head Injuries	Y	N	Thyroid Adrenal Disease
Y	N	Heart Attack	Y	N	Tuberculosis
Y	N	Heart Disease	Y	N	Ulcers

Please List any other serious medical condition(s) that have (had) which are not listed above:

_____

_____

_____

_____

Penicillin No Allergies

Dental History:

What is your primary reason for your visit to our practice today? _____

Are you currently in pain? Y N

Do you require antibiotics (premed) before dental treatment? Y N

Your current dental health is:

Good Fair Poor

When was the last time you had a complete dental evaluation? _____

Have you ever been informed or treated for the following dental conditions?

Y	N	Bleeding gums
Y	N	Bad Taste/Odor
Y	N	Cold Sores/Ulcers
Y	N	Deep Cleanings/Scaling
Y	N	Gum/Periodontal Disease
Y	N	Hot/Cold Sensitivity
Y	N	Mobility of Teeth
Y	N	Oral Cancer/ Biopsy
Y	N	Osseous Surgery
Y	N	TMJ/TMD Joint Pain
Y	N	Toothbrush Abrasion
Y	N	Wisdom Teeth Extractions

Have you ever had a serious/difficult problem associated with previous dental work? Y N

If yes, explain:_____

_____

Do you floss regularly? Y N

Do you brush daily? Y N

Would you like fresher breath? Y N

Would you be interested in whiter teeth? Y N

Are you happy with the way your smile looks? Y N

If not, what would you like to change?

_____

I understand that the information I have given today is correct and accurate to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I hereby authorize treatment and the use of local anesthesia and other medications as necessary for dental treatment to be rendered by the dentist and the dental staff.

Patient/Parent/Guardian Signature Date

Cancellation Policy

The cancellation policy of this office requires a 48 hour, or a two business day notice prior to your scheduled appointment time. **Failure to notify us properly will result in a failed appointment charge of $55.00. This charge must be paid in full before your next visit to our office.** Multiple missed appointments would call for a deposit of $55 to reserve time in the doctor's schedule.

Patients with government subsidized insurance (ie: HIP, HHW, Medicaid, etc.) in which we are not permitted to charge no-show fees will be put on a call list or dismissed from our practice with failure to give a 48 hour notice.

Confirmation Policy

Our office sends multiple forms of reminders of upcoming appointments, including post cards, emails and texts, as well as making personal confirmation calls two days in advance. In order to hold appointments, we do require that you confirm your appointments through our texting/email system or verbal confirmation on the phone. If we are not able to get a hold of you, leave a message on your voicemail, or if you fail to confirm your appointment, it will result in the removal of your allotted appointment time from our schedule, and it will be your responsibility to call us to reschedule your appointment.

Financial Responsibility

Our office is an in-network provider for most insurance policies, and we will prepare the necessary forms for dental insurance in order to gain the most-accurate information regarding your individual insurance plan. Your individual insurance policy is an agreement between you and your insurance company, not between your insurance company and our office.

Your insurance policy is verified at your initial appointment as the doctor diagnoses necessary treatment. Insurance plans are not designed to dictate what treatment is deemed necessary; we do our best to make you aware of the estimated costs with insurance; however, verification of insurance is always an estimate, **not a guarantee of payment**. Insurance plans often downgrade payment on some procedural codes; most dental insurance plans also allow an annual maximum that they will pay for services. We do our best to inform you about insurance coverage including procedural codes and maximums; **however, it is your responsibility to know and understand your insurance plan and coverage. Any balances from services that were performed in our office and not covered by insurance are your responsibility to pay.**

I hereby authorize the release of any information, including any diagnostic records (x-rays, photographs, charting) to my insurance company. I hereby authorize my insurance company to pay directly to Christiaan A. Willig D.D.S. any proceeds payable under the terms of my insurance policy. I understand that I am responsible for my dental bills and the balance on my account regardless of my insurance coverage. I hereby authorize Christiaan A. Willig D.D.S. to perform dental procedures on me, my minor children and / or family members. I understand that I will incur a 18% per annum finance charge if my balance goes beyond 30 days. I understand that I will incur a $40 charge on returned checks along with any bank fees charged to Dr. Willig. I understand in the event that my account is turned over to an outside collection agency that I am responsible for all fees including but not limited to, collection fees, late charges, interest fees, attorney fees, court costs, and legal interest including a $55 collections processing fee. I hereby authorize the use of the telephone numbers that I have provided for clinical and collective purposes. I have read and understand the financial policy statement provided to me by office staff.

I have read and fully understand the above office policies regarding payment, cancellations, and I accept the terms as they were presented to me.

Date:_____Signature:_____

Print Name: _____

HIPPA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY AND SIGN THE BOTTOM OF THE PAGE STATING "ACKNOWLEGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES."

This notice of privacy practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment, or healthcare operation (TPO) and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical mental health condition and related health care services.

Uses and Disclosures of Protected Health Information

1. **Uses and Disclosures of Protected Health Information**
   Your protected health information may be used and disclosed by your dentist, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the dentist's practice, and any other use required by law.

2. **Treatment**
   We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health information may be provided to a dentist to whom you have been referred to ensure that the dentist has the necessary information to diagnose or treat you.

3. **Payment**
   Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

4. **Healthcare Operations**
   We may use or disclose, as needed, your protected health information to support the business activities of your dentist's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, or conducting and arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office.
   In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your dentist. We may also call you by name in the waiting room when your dentist is ready to see you. We may use or disclose your protected health information as

necessary to contact you to remind you of your appointment. We may use or disclose your protected health information in the following situations without your authorization. These situations include: As Required by Law: Public Health Issues, Communicable Diseases, Health Oversight, Abuse or Neglect, FDA requirements, Legal Proceedings, Law Enforcement, Coroners, Funeral Directors, Organ Donation; Research: Criminal Activity, Military Activity and National Security, Workers' Compensation, Inmates, Required Uses and Disclosures. Under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

5. **Other Permitted Uses and Disclosures**
   Will be made only with your consent, authorization, or opportunity to object unless required by law.

You may revoke this authorization at any time in writing, except to the extent that your dentist or the dentist's practice has taken an action in reliance on the use or disclosure indication in the authorization.

Your Rights

1. **You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law and prohibits access to protected health information.
2. **You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your dentist is not required to agree to a restriction that you may request. If the dentist believes it is in your best interest to permit use and discloser of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.
3. **You have the right to request to receive confidential communications from us by alternative means or at an alternative location.**
4. **You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.
5. **You may have the right to have your dentist amend your protected health information.** If we deny your request for amendment, you have a right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
6. **You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before April 11, 2005.

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our main phone number.

Your signature below is an acknowledgement that you have read and understand this Notice of our Privacy Practices. If you would like a copy for your records please let your request be known with our front desk personnel.

Signature(Parent/Guardian if under 18): _____

Printed Name (Parent/Guardian if under 18): _____

Date: _____

Dental Treatment Consent Form

Patient Name _____ Birth date_____

Please read and initial the items checked below. Then read and sign the section at the bottom of the form

☐ Drugs and Medications

I understand that antibiotics, analgesics, anesthesia, and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). Possible prolonged numbness can occur after anesthetic injections.

☐ Fillings

I understand that care must be exercised in chewing on silver fillings during the first 24 hours to avoid breakage. I understand that I may experience some sensitivity to temperature change and hard foods for up to one month following placement of fillings. I give permission to the dentist to make any/all changes and additions as necessary.

☐ Removal of Teeth

Alternatives to removal have been explained to me (root canal therapy, crowns, and periodontal surgery, etc.) and I authorize the dentist to remove the following teeth _____ and any others necessary for reasons in paragraph #2. I understand that removing teeth doesn't always remove all the infection, if present and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in teeth, lips, tongue and surrounding tissue (Paresthesia) that can last for an indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.

☐ Crown, Bridge, and Caps

I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge, or cap (including shape, fit, size, and color) will be cementation. I give my permission to the dentist to make any/all changes and additions as necessary.

☐ Dentures (Complete or Partial)

I realize that full or partial dentures are artificial, constructed of plastic, metal and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize the final opportunity to make changes in my new denture (including shape, fit, size, placement, and color) will be the "teeth in wax" try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

☐ Endodontic Treatment (Root Canal)

I realize there is no guarantee that root canal treatment will save my tooth, that complications can occur from the treatment and that occasionally objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot guarantee results. I acknowledge that no guarantee or assurance has been made to me by anyone regarding the dental treatment that I have requested and authorized for my minor child or myself. I have had full opportunity to discuss and ask questions regarding the dental treatment, and all questions have been answered to my satisfaction.

Signature (Parent/Guardian if under 18): _____ Date: _____

Printed Name (Parent/Guardian if under 18): _____