Winkler Dental Clinic

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Chart#: _____
FOR OFFICE USE ONLY

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

Title: _____ **Gender:** ◯ Male ◯ Female ◯ Other **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ ____ ___-___
City PV Postal Code

What is the date (or approximate date) of your last MEDICAL/FAMILY doctor's appointment?

_____

_____

Who is your medical doctor and what is the name of the clinic?

_____

_____

What is the name of your preferred pharmacy?

_____

_____

Please mark the box if your response is yes to any of the following questions:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Are you currently taking any prescription or non-prescription medications?

Please explain any items checked above and provide list of medications:
(if unsure of medications, please notify reception and we can request a list from your pharmacy)

_____

_____

WOMEN ONLY: If pregnant, when is your due date? _____

- [ ] *Pre-Med(antibiotic)
- [ ] Acid Reflux
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Atrial Fibrillation
- [ ] Cancer(past/present)
- [ ] Cognitive Delay
- [ ] Diabetes
- [ ] Excessive Bleeding
- [ ] Gastro-Intestinal
- [ ] Hay Fever
- [ ] Heart Surgery
- [ ] High Blood Pressure
- [ ] Low Blood Pressure
- [ ] Pacemaker
- [ ] Respiratory Problems
- [ ] Sinus Problems
- [ ] TMD
- [ ] Ulcers
- [ ] *PreMed(antianxiety)
- [ ] Allergy - Codeine
- [ ] Allergy- Amoxicillin
- [ ] Arthritis
- [ ] Autism
- [ ] Celiac
- [ ] Contraceptive Use
- [ ] Dizziness/Fainting
- [ ] Excessive Bruising
- [ ] Glaucoma
- [ ] Head Injury
- [ ] Hepatitis A
- [ ] Jaundice
- [ ] Mental Health Issue
- [ ] Parkinsons
- [ ] Rheumatic Fever
- [ ] Skin Rash
- [ ] Thyroid Disease
- [ ] *See Patient Notes
- [ ] Allergy - Latex
- [ ] Allergy-Local Anesth
- [ ] Artificial Joints
- [ ] Blood Disorder
- [ ] Chronic Migraines
- [ ] Crohn's disease
- [ ] Emphysema
- [ ] Fibromyalgia
- [ ] HIV+ (AIDS)
- [ ] Heart Disease
- [ ] Hepatitis B
- [ ] Kidney Disease
- [ ] Multiple Sclerosis
- [ ] Pregnancy
- [ ] Rheumatism
- [ ] Stomach Problems
- [ ] Tuberculosis
- [ ] ADHD
- [ ] Allergy - Other
- [ ] Allergy-Penicillin
- [ ] Asthma
- [ ] COPD
- [ ] Clotting Disorder
- [ ] Dental Anxiety
- [ ] Epilepsy
- [ ] Gag reflex
- [ ] Hard To Freeze
- [ ] Heart Murmur
- [ ] Hepatitis C
- [ ] Liver Disease
- [ ] Nervous Disorders
- [ ] Radiation Treatment
- [ ] STD
- [ ] Stroke
- [ ] Tumors

Please indicate any other health conditions, diseases or allergies not listed above that we should be aware of.

_____

_____

_____

- [ ] **To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.**

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids with my verbal consent at each appointment.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

Signature _____ **Date** _____

Consent for Services

Any balance on the account for services rendered will be the responsibility of the undersigned regardless of insurance involvement. I will pay my balance on the day of treatment. Any discrepancy between what is understood that insurance would pay and what they actually pay automatically becomes my responsibility. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

By signing below I assign my dental benefits (if applicable) for dental claims submitted electronically by Winkler Dental Clinic and authorize payment directly to the Winkler Dental Clinic. This authorization shall continue in effect until the undersigned revoked the same.

The Winkler Dental Clinic requires one business day notice for any appointment changes or cancellations. We reserve the right to charge a fee of $107.40 in the event that this policy is not adhered to. The fee must be paid before any appointment will be rescheduled for yourself or any family member.

☐ **I have read the above conditions of treatment and payment and agree to their content.**

Signature of patient, parent, or guardian (responsible party):

ELECTRONIC SIGNATURE REQUIRED - PLEASE BRING FORM TO FRONT RECEPTION FOR SIGNATURE.

Signature _____ **Date** _____

Response Date: _____