Windermere Family Dentistry Patient Registration

Name: _____ Spouse: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Email address: _____

Date of birth: _____ Age: _____ ☐ Male ☐ Female

Immediate family members? _____

Please check your preference for appointment reminders. ☐ Email ☐ Text ☐ Phone

Responsible Party (if different from above)

Name: _____ Relation: _____

Home address: _____

City: _____ State: _____ Zip: _____

Home # _____ Cell # _____ Work # _____

Date of birth: _____ Age: _____ Sex: _____

Dental Insurance Information

Primary Insurance

Policy holder's name: _____

SS# _____ Employer: _____

Date of birth: _____ Relationship to patient: _____

Name of Ins. Co.: _____ ID #: _____ Group #: _____

Ins. mailing address: _____

City: _____ State: _____ Zip: _____

Ins. Phone # _____

Secondary Insurance

Policy holder's name: _____

SS# _____ Employer: _____

Date of birth: _____ Relationship to patient: _____

Name of Ins. Co.: _____ ID #: _____ Group #: _____

Ins. mailing address: _____

City: _____ State: _____ Zip: _____

Ins. phone # _____

Referral Information

Whom may we thank for referring you to our office: _____

When was your last dental check-up? _____

When was your last medical check-up? _____

Who is your medical doctor? _____ Phone # _____

Payment / Cancellation Policies

Please help us keep the office running smoothly and efficiently. We make every effort to stay on schedule for your benefit and convenience. In return, we respectfully ask patients to fulfill scheduled appointments and be prompt.

Our standard office policy regarding appointments is as follows:

As a courtesy, we attempt to remind patients by telephone three business days prior to an appointment and by text and email 2 days before an appointment. If we are unable to contact you, your appointment card will serve as the confirmation of your appointment and implies you are obligated to be present. That time has been reserved especially for you.

If you need to change your appointment, please contact the office at least 2 business days prior to the appointment scheduled. This will alleviate any late charge that will normally incur.

We understand there are certain circumstances that prohibit you from doing this. Exceptions to this rule can be determined on an individual basis according to circumstances.

Insurance Policy

Thank you for taking the time to educate yourself on your particular insurance plan benefits. It is important that you understand your benefits and our office policy.

Dental insurance companies do not intend for their plans to cover all expenses. Their plans serve only as an aid toward acquiring better care.

The amount your plan pays is determined by how much you or your employer paid for the plan. The less that is paid for the insurance, the less you benefit. Insurance benefits packages vary from company to company, and we will gladly assist you with your insurance carrier before treatment.

Please understand that NOT ALL procedures are covered benefit in your plan. We will make every effort to know what your plan covers prior to the beginning treatment but ultimately it is your responsibility to know what is covered under your plan.

We require your application deductible plus your out-of-pocket costs at the time of service.

Some insurance companies tell their clients that "fees are above the usual and customary fees" rather than saying that" their insurance benefits are too low." In our office we do not view our patients as "usual and customary," but as quality people who expect quality dentistry. Remember, your insurance benefit is limited by what your employer pays for the plan less the profits of the insurance company.

Billing Policy

We process all patient accounts through First Pacific Corporation, which states the following explanation of late and finance charges. Late Charge: If your minimum payment is not received by the due date you may be assessed a late payment charge. The amount of the late payment charge to be assessed is the maximum amount authorized under the laws of the state of your domicile. In most states, the late charge will be $5.00 or 5% of the past due minimum payment, whichever is greater with a maximum of $20.00. Finance Charge: The periodic finance rate is 1.25% monthly with a minimum of $1.00 being imposed.

I have read, understand and agree to the above office policies. I understand that I am fully responsible for all fees of the services rendered, regardless of insurance coverage.

I understand that my estimated out-of-pocket costs and deductible is due at the time of service.

_____ Date: _____

Signature of Patient / Account Holder, Parent or Legal Guardian

Patient Medical Questionnaire

How is your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have, or have you had, the following?

☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No	Stroke
☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No	Epilepsy
☐ Yes	☐ No	Low Blood Pressure	☐ Yes	☐ No	Venereal Disease
☐ Yes	☐ No	Joint Replacement	☐ Yes	☐ No	Positive HIV / AIDS
☐ Yes	☐ No	Bleeding Problems	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Heart Attack	☐ Yes	☐ No	Fainting
☐ Yes	☐ No	Rheumatic Fever	☐ Yes	☐ No	Ulcers
☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Psychiatric Treatment
☐ Yes	☐ No	Cancer	☐ Yes	☐ No	Sinus Problems / Allergies
☐ Yes	☐ No	Radiation Treatment	☐ Yes	☐ No	Thyroid Disease
☐ Yes	☐ No	Asthma / Emphysema	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Arthritis
☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Kidney Disease
☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Bisphosphonate Therapy
☐ Yes	☐ No	Cochlear Implant	☐ Yes	☐ No	Sleeping Disorder

Are you allergic to any drug, medicine, or supplement? ☐ Yes ☐ No

Explain: _____

Have you ever been hospitalized? ☐ Yes ☐ No

Explain: _____

Have you had surgery in the past five years? ☐ Yes ☐ No

Explain: _____

Are you under the care of a physician now? ☐ Yes ☐ No

Explain: _____

Are you taking medication, drugs or vitamins? ☐ Yes ☐ No

Explain: _____

Do you have any disease or problems not listed above? ☐ Yes ☐ No

Explain: _____

Do you use tobacco products? ☐ Yes ☐ No If yes, what kind? _____

Do you wear contact lenses? ☐ Yes ☐ No

Women

Are you pregnant? ☐ Yes ☐ No Delivery date: _____

Are you taking birth control pills?

Patient Dental Questionnaire

Is any part of your mouth sensitive to temperature or pressure?	☐ Yes	☐ No
Do your gums bleed when you brush or floss?	☐ Yes	☐ No
Have you ever been told that you have a gum problem?	☐ Yes	☐ No
Have you ever been treated for gum disease?	☐ Yes	☐ No
Have you ever had orthodontic treatment? (Braces)	☐ Yes	☐ No
Have you ever had an injury to your teeth?	☐ Yes	☐ No

Explain: _____

Have you ever had any injuries to your face or jaw / jaw joints? ☐ Yes ☐ No

Explain: _____

Patient Medical Questionnaire Continued

Have you lost any teeth?	☐ Yes	☐ No
If so, why? _____		
Does food catch between your teeth?	☐ Yes	☐ No
Are you dissatisfied with the color of your teeth and their appearance?	☐ Yes	☐ No
Is there anything you would like to change about the way your teeth look or feel?	☐ Yes	☐ No
Do you clench or grind your teeth during the day?	☐ Yes	☐ No
Have you been made aware of clenching or grinding your teeth at night?	☐ Yes	☐ No
Do you have chronic headaches, neck or shoulder pain?	☐ Yes	☐ No
Do you now, or have you ever had, pain in your jaw joints or the side of your face?	☐ Yes	☐ No
Have you ever had a click, pop, or other noise in your jaw joint?	☐ Yes	☐ No
Have you ever been unable to move your jaw or open your mouth widely?	☐ Yes	☐ No
Do you snore?	☐ Yes	☐ No
Have you been diagnosed with sleep apnea?	☐ Yes	☐ No

Denture Patients

How long have you worn dentures? _____

Why were your teeth extracted? _____

How did you feel about getting dentures? _____

_____

If you are currently having a denture problem, is it due to: ☐ Pain ☐ Discomfort ☐ Appearance ☐ Function

Everyone

Do you have any other dental concerns? _____

_____

Do you have any dental needs that should be addressed today? _____

_____

Consent

I certify that all the above information is correct and I am responsible for all medical information and will bring any changes to the attention of this office. I consent to treatment as necessary or desirable to the care of the patient named above, for the diagnosis of dental disease, deformity, or treatment of dental emergency. I consent to procedures deemed necessary by the doctor, understanding that the procedures will be explained in advance.

Financial Agreement

I acknowledge that payment is due at the time of treatment, unless other arrangements are made. I agree that parents, guardians, or personal representatives are responsible for all fees and services rendered for treatment of a minor / child. I accept full financial responsibility for all charges for services or items provided to me or the patient. I understand I am responsible for all collection costs, court costs & responsible for attorney fees. I understand that filing a claim with my insurance company does not relieve me from my responsibility for the payment of all changes.

I Have Read and Understand and Agree to the Above Policy

_____ Date: _____

Signature of Patient / Account Holder, Parent or Legal Guardian

Windermere Family Dentistry Sleep Screening Questionnaire

This questionnaire was designed to provide important facts to best address how we may help your overall health if you suffer from sleep disordered breathing. To assist in determining the source of any problem, please take your time and answer each question as completely and honestly as possible. There is often a correlation between grinding of the teeth, TMJ disorders, breakdown of the teeth and sleep disorders. Sleep apnea may also increase your risk for many different health conditions including heart attack and stroke.

Name: _____ Height: _____ Weight: _____

Please check any of the following that may concern you or that you struggle with:

- ☐ Frequent heavy snoring
- ☐ Snoring that affects the sleep of others
- ☐ Sleep apnea
- ☐ CPAP intolerance
- ☐ Significant daytime drowsiness
- ☐ Difficulty falling asleep
- ☐ Gasping when waking up
- ☐ Nighttime choking spells
- ☐ Swelling in ankles or feet
- ☐ I have been told that "I stop breathing" when sleeping
- ☐ Feeling un-refreshed in the morning
- ☐ Morning hoarseness
- ☐ Morning headaches
- ☐ Nocturnal teeth grinding
- ☐ Jaw pain
- ☐ Facial pain
- ☐ Jaw clicking
- ☐ High blood pressure

Would you be interested in a consult for Invisalign style braces? ☐ Yes ☐ No

Other: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired?

0 = I would never doze

1 = I have a slight chance of dozing

2 = I have a moderate chance of dozing

3 = I have a high chance of dozing

Situation	Chance of Dozing
1. Sitting and reading	_____
2. Watching TV	_____
3. Sitting inactive in a public place (e.g. a theatre or a meeting)	_____
4. As a passenger in a car for an hour without a break	_____
5. Lying down to rest in the afternoon when circumstances permit	_____
6. Sitting and talking to someone	_____
7. Sitting quietly after lunch without alcohol	_____
8. In a car while stopped for a few minutes in traffic	_____
Total Score	_____

Dr. Claire-Marie Bender, DMD
Dr. Winston White, DMD, FAGD

Acknowledgement of Receipt of Notice of Privacy Policies

I acknowledge that I have reviewed a copy of the Notice of Privacy Policies.

Signature_____ Date_____

Name (please print) _____

This information is intended as advisory in nature and should not be considered as legal advice nor is it a substitute for legal advice. This information does not constitute technical information system/security advice. It is designed to assist you in your own risk management activities. It I not intended to be exclusively relied upon or used as a substitute for your own loss-control program. Accuracy and completeness are not guaranteed.