STAUNTON SMILES

Dentistry for Adults

DOUGLAS WRIGHT, DDS
MICHAEL KENNEDY, DDS

Patient Information

First Name_____ **Middle Initial** _____**Last Name** _____

Birth Date _____ **SSN #** _____**Gender** _____ **Marital** _____

Home Address _____

Home Phone# _____ **Cell Phone#** _____

Spouse's Name _____ **Birth Date** _____**Phone#** _____

Emergency Contact Name _____**Phone#** _____**Relation** _____

How did you hear about our office? _____

E-mail Address _____

☐ *Please check to opt into automated emails and text messages from our office.*

INSURANCE INFORMATION

Insurance Company _____ Phone #_____

Address_____

Relationship to Patient: Self ( ) Spouse ( ) Policyholder's Birth Date ____ / ____ / _____

Group # _____ Group Name _____

Policy ID #_____ Policyholders SSN#_____

Time 9:46 AM

Douglas D. Wright, DDS

Date 5/9/2023

Medical History 2023

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Do you have a Primary Care Provider?	◯ Yes ◯ No	If yes
Have you ever had a major operation or an injury to the head or neck?	◯ Yes ◯ No	If yes
Have you been to the Emergency Room in the the last 6 months?	◯ Yes ◯ No	If yes
Are you currently taking a Blood Thinner? If yes, which one?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Please list ALL Medications you are currently taking:

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Iodine	☐ Biphosphonates		

Other? ☐ If yes

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

Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No	Alzheimer's Disease	◯ Yes ◯ No
Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No	Anaphylaxis	◯ Yes ◯ No
Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No	Anemia	◯ Yes ◯ No
Easily Winded	◯ Yes ◯ No	Herpes	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizziness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Genital Herpes	◯ Yes ◯ No	Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No
Glaucoma	◯ Yes ◯ No	Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No
Hay Fever	◯ Yes ◯ No	Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No
Heart Attack/Failure	◯ Yes ◯ No	Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No
Heart Murmur	◯ Yes ◯ No	Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No
Heart Pacemaker	◯ Yes ◯ No	Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No
Heart Trouble/Disease	◯ Yes ◯ No	Psychiatric Care	◯ Yes ◯ No	Venereal Disease	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No
AIDS/HIV Positive	◯ Yes ◯ No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

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:

X Date:_____

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ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received and reviewed a copy of Dr. Douglas D. Wright's HIPAA Notice of Privacy Practices.

I understand that Dr. Douglas D. Wright's HIPAA Notice of Privacy Practices may change periodically and that I am entitled to receive a copy of Dr. Douglas D. Wright's revised HIPAA Notice of Privacy Practices upon request.

I understand that, if I have questions about Dr. Douglas D. Wright's HIPAA Notice of Privacy Practices, I may contact the office at 540-688-2123.

I understand that it is my right to refuse to sign this Acknowledgement should I so choose, and that Dr. Douglas D. Wright will not refuse treatment to me if I refuse to sign this Acknowledgement.

I further understand that I may contact the Secretary of the U.S. Department of Health and Human Services should I have concerns regarding Dr. Douglas D. Wright 's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, please for assistance.

Patient/Guardian Signature : _____ Date: _____

FOR OFFICE USE ONLY

Dr. Douglas D. Wright made a good-faith effort to obtain Acknowledgement, from the patient noted above, of receipt of its HIPAA Notice of Privacy Practices. In spite of these efforts, Dr. Douglas D. Wright was unable to obtain a signed Acknowledgement for the following reason(s):

- o Refusal to sign Acknowledgement on _____, 20_____.
- o Communications barriers prohibited us from obtaining a signed Acknowledgement.
- o An emergency situation prohibited us from obtaining a signed Acknowledgement.
- o Other (Describe): _____

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Assignment and Release

I understand that I am financially responsible for all charges and services rendered to me or my dependents, whether paid for or not paid by insurance. I understand that Staunton Smiles is Out of Network with all insurance companies. As a courtesy to me they will process my insurance claims. I understand that I will be provided with an insurance estimate, however, it is not a guarantee that my insurance will pay exactly as estimated.

Payment Policy

Payment is due at the time service is provided. Deposits are collected at the time of scheduling and will go towards the out of pocket amount for the scheduled treatment. Our office accepts cash, personal checks, credit cards and outside patient financing. If I am reconsidering treatment that I have not yet received but have already paid for, I may cancel treatment and request a refund at any time for the amount paid. **Note:** *If my case has been submitted for fabrication to a dental lab, I will be responsible for the lab fee.* I also understand that I am billed a $35.00 return check fee for any checks returned for insufficient funds.

Cancelation Policy

A minimum charge may be billed for missed or cancelled appointments without prior notification of 24 hours. I understand that failure to give a 24 hour notice that I cannot keep a reserved appointment will result in a **missed appointment fee of $100.00** and, should this happen 3 times, will result in dismissal from the practice. Our office reserves the right to refuse appointments for late cancellations as well as failure to attend. Please remember that once an appointment is made, this time is reserved especially for you.

Consent for Use/Disclosure of Health Information

By signing this form you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and health care operations. Your signature also indicates that you have had full opportunity to read and consider our Notice of Privacy Practices, and that you understand that you have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed on that notice. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you and or to continue treating you if you revoke this consent.

Consent for Dental Photography

I hereby consent to the taking of photographs, videos, and/or digital images of my teeth, mouth, and face by Staunton Smiles. I understand these images may be used for treatment planning, medical records, education, and/or marketing purposes (with personal identifiers removed, if applicable.) I release Staunton Smiles from any liability that may arise from the use of these images described.

- ☐ **I consent** to the use of my images for marketing/social media purposes
- ☐ **I do NOT consent** to the use of my images for marketing/social media purposes. (Images will only be used for treatment and records)

I, the undersigned, understand and agree to the policies stated above. I certify that the information on this form is accurate, to the best of my knowledge.

Name (Printed) _____ Date _____

Patient Signature _____