SILVERWOLF
D·E·N·T·A·L

***Jason Wareham, DMD & Andrew Smith, DMD***

*Family & Cosmetic Dentistry*

## ***New Patient Information***

Name: _____ Pref. Name: _____ Birth Date: _____
Home Phone: _____ Cell Phone: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Driver License: _____
Check appropriate box: Single ___ Married ___ Divorced ___ Widowed ___ Separated ___

Whom may we thank for referring you? _____
Emergency Contact: _____ Phone _____

## ***Responsible Party***

Name: _____ Pref. Name: _____ Birth Date: _____
Home Phone: _____ Cell Phone: _____ SSN: _____
Address: _____ City: _____ State: _____ Zip: _____
Email: _____ Driver License: _____
Employer: _____ Work Phone: _____

## ***Insurance Information***

Name of subscriber: _____ Relationship: _____
Birth date: _____ SSN: _____ Name of employer: _____
Insurance company _____ Phone No: _____
Member ID: _____Group No. _____
Address _____ City _____ State _____ Zip_____

**Payment in full is due at time of service.**

I agree to pay all services provided to me or to members of my family by Silverwolf Dental. I understand that Silverwolf Dental will seek payment from my insurance company for amounts covered by insurance. I understand, however, that even if my insurance provider fails to pay for the dental service, I am ultimately responsible to pay all amounts in full within 90 days from the date of service. If I fail to pay within the 90 days, I agree to pay a finance charge of 1.5% per month (18% per year) of the unpaid balance. Should collections become necessary, I agree to pay all collection costs and all legal fees dealing with collections, with or without suit, including attorney fees and court costs. I understand that I will be charged $66.00 if I cancel a scheduled appointment within 24 hours of that appointment. I further understand that, due to office policy and certain insurance contracts, cancellation fees are non-negotiable and will not be removed from my account. Should any conflict arise between this agreement and previous patient forms, the terms of this agreement will supersede.

Signature _____ Date _____

Silverwolf Dental Spa

# Eaglesoft Medical History

Patient Name: Birth Date: Date:

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

| | | |
|---|---|---|
| Are you under a physician's care now? | Yes No | If yes |
| Have you ever been hospitalized or had a major operation? | Yes No | If yes |
| Have you ever had a serious head or neck injury? | Yes No | If yes |
| Are you taking any medications, pills, or drugs? | 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 |
| Are you on a special diet? | Yes No | |
| Do you use tobacco? | Yes No | |
| Do you use controlled substances? | Yes No | If yes |

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 |

Other? ☐ If yes

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| AIDS/HIV Positive | Yes No | 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 |

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

Comments:

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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**Insurance & Billing Information**

For your information this letter is to help you better understand the complexities of dental insurance; we realize how confusing it can be. To begin, we would like to highlight a misconception – Dental Insurance was not designed to pay for all dental care. Most contracts have limits and/or various degrees of co-payments, deductibles and yearly maximums.

As a courtesy we verify the basics of a patients plan. Your Employer dictates the benefits that are paid. Please take time to read the booklet of Benefit Information given to you, so you will be aware of your benefits, Deductibles, Co-pays, Yearly Maximums, waiting periods, and if your insurance company downgrades Composites to Amalgams, Porcelain Crowns to All Metal & Inlays/Onlays to 2 surface Resins.

_____
Initials

All levels of payment by insurance companies, including allowed fees, usual and customary (UCR), are governed by the premiums paid. They have nothing to do with the actual charges. Our fees are based upon a combination of our costs, our time, and our constant dedication to supplying our patients with the highest quality dental care. The treatment recommended by our office is never based on what your insurance company will pay; your treatment should not be governed by your insurance contract.

It should be understood, that the dental insurance contract is between the insurance company and you the patient, it is your responsibility to know your policy (downgrades, waiting periods, missing tooth clauses etc.), you the patient bears the ultimate financial responsibility.

As a courtesy, we will directly bill your insurance company. If your insurance company has not paid us within 30 days from the time claim is sent, we will grant you another 30 days to contact your insurance company and demand payment. If no payment is received by the end of the 60-day period, you will be responsible to pay the full amount due and seek reimbursement directly from your insurance company. We do bill secondary insurance; please let us know if you have double coverage.

After Insurance pays in full, and the balance is known; a statement will be sent and payment in full will be due upon receipt.

We hope this information has been helpful. Please take the time to review your contract thoroughly so we may best serve you. As always, please feel free to ask any member of our staff for clarification on services, billing and insurance.

**I have read and understand the Insurance Policies and agree to abide to the terms of this office.**

**Signature** _____ **Date**_____

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# Jason Wareham, DMD &Andrew Smith, DMD

Family & Cosmetic Dentistry

## PLEASE READ CAREFULLY

We would like to take this opportunity thank you for choosing SilverWolf Dental as your dental health care provider.

**Appointments:**
We extend our appreciation by respecting you and your valuable time. We strive to keep your wait after check-in to a minimum. We ask that in return, you respect our time.
If you are more than 15 minutes late for your reserved time, you may be asked to reschedule.
A 24 business hours notice of cancellation must be given in order to avoid a $66 missed appointment fee.
I grant my permission to you or your assignee to telephone me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and/or results on my answering machine or with a family member.

**Emergency Care:**
If you or your family members have an accident or need assistance after regular office hours, call our main number and listen on how to contact one of the doctors. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are rendered. Care received during non-office hours is subject to an additional charge.

**Payments:**
We accept cash, personal checks, money orders, debit cards and all major credit cards. Payment is due at the time of service. A $25.00 processing fee will be added to your account for any returned checks. If payment arrangements are made, a $25.00 late fee will be added to your account if payment is not made by the due date each month.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

**Collections & Interest:**
I agree to pay interest at the rate of 1.5% (18% annually) on all past due balances from the original due date, plus court costs and reasonable attorneys' fees, with or without suit, incurred in collecting any past due balance, and a collection fee if my account is assigned to a collection agency.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by fax or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have had the opportunity to see and read the Privacy Policies of this office. I agree to disclose to the dentist names of any individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein. We again thank you for your patronage and cooperation.

**I UNDERSTAND AND AGREE TO ABIDE BY THE TERMS OF THIS OFFICE.**

Signature: _____ Date: _____

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**Consent to Proceed and Health Questionnaire Acknowledgement:**
I certify that the answers to the health questions are accurate and correct to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent appointment.

I authorize **Dr. Smith and/or Dr. Wareham** or assistants as he may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or the dental health of any minor or other individual for which I have responsibility, including arrangement and/or administration of any sedative (including nitrous oxide), analgesic, therapeutic and/or pharmaceutical agent(s), including those related to restorative, palliative, therapeutic or surgical treatments.

I understand that the administration of local anesthetic may cause an untoward reaction or side effect, which may include, but are not limited to bruising, hematoma, cardiac stimulation, temporary or rarely, permanent numbness, and muscle soreness. I understand that occasionally needles break and may require surgical retrieval.

I understand that as part of the dental treatment, including preventive procedures such as cleanings and basic dentistry, including fillings of all types, teeth may remain sensitive or even possibly quite painful both during and after completion of treatment. After lengthy appointments, jaw muscles may also be sore or tender. Gums and surrounding tissues may also be sensitive or painful during and/or after treatment. Although rare, it is also possible for the tongue, cheek or other oral tissues to be inadvertently abraded or lacerated (cut) during routine dental procedures. In some cases, sutures or additional treatment may be required.

I understand that as part of dental treatment items including, but not limited to crowns, small dental instruments, drill components, etc. may be aspirated (inhaled into the respiratory system) or swallowed. This unusual situation may require a series of x-rays to be taken by a physician or hospital and may, in rare cases, require bronchoscopy or other procedures to ensure safe removal.

I understand the need to disclose to the dentist any prescription drugs that are currently being taken or that have been taken in the past, such as Phen-fen. I understand that taking the class of drugs prescribed for the prevention of Osteoporosis, such as Fosamax, Boniva or Actonel, may result in complications of non-healing of the jawbones following oral surgery or tooth extractions.

I do voluntarily assume all possible risks, including the risk of substantial and serious harm, if any, which may be associated with general preventative and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved, for my benefit or the benefit of my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions.

**Patient Name:** _____

**Signature:** _____ **Date:** _____