Date _____

GETTING TO KNOW YOU AS OUR PATIENT

PATIENT NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	❑ M ❑ F	Drivers License and State

Primary Insurance Company _____ Group _____ Subscriber _____

Secondary Insurance Company _____ Group _____ Subscriber _____

Responsible Party

NAME	SOCIAL SECURITY NUMBER	HOME PHONE ( )
Home Address	City, State, Zip	Birthdate / /
Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Separated	Relationship to Patient	Drivers License and State
Responsible Person's Employer	Occupation	Work Phone ( )
Business Address	City	State Zip
Spouse's Name	Social Security Number	Birthdate / /
Spouse's Employer	Spouse's Occupation	Spouse's Work Phone ( )
Spouse's Business Address	City	State Zip

How did you hear about our Office?

(check only one)

Who selected this Office? ❑ Self ❑ Spouse ❑ Parent ❑ Employer

Where did you find the Phone Number to this Office? _____

❑ Referred by a friend ❑ Yellow Pages ❑ Relative ❑ Insurance Plan ❑ Welcome Wagon

❑ Other_____ ❑ TV/Radio Ad ❑ Newspaper Ad ❑ Direct Mailing ❑ Sign by Building

If you were referred, whom may we thank for referring you? _____

CONSENT

•I will answer all health questions to the best of my knowledge _____
Initial

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgement of the doctor may decide in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor.

Signature Date Relationship to Patient

TERMS AND CONDITIONS

This office depends upon reimbursement from the patient for the costs incurred in their case. The financial responsibility of each patient must be determined before treatment.
As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental service performed without prior financial arrangements, must be paid for at the time the services are performed.
I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize releases of any information needed and also authorize my insurance company to pay directly to this Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

Signed _____ **Date** _____

There may be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment time.

PATIENTS DENTAL HEALTH

Why have you come in to see us today? (e.g.: pain, checkup, etc.)_____

Previous Dentist_____ Last Visit_____ Date of last cleaning_____

Reasons for changing dentists:_____

What problems have you had with past dental treatment?_____

Are you nervous about seeing a dentist? ❑ Yes! ❑ No If yes, please tell us why:_____

How often do you brush?_____ Do you floss? ❑ Yes ❑ No How often?_____

(please circle each)

Y N I clench or grind my teeth during the day or while sleeping.
Y N My gums bleed while brushing or flossing.
Y N I like my smile.
Y N I prefer tooth-colored fillings.
Y N I avoid brushing part of my mouth due to pain.
Y N My gums feel tender or swollen
Y N I have problems eating.
Y N I have had orthodontics.
Y N I have had a facial or jaw injury.
Y N I want my teeth straight.
Y N I want my teeth whiter.

What are your dental priorities?_____
(e.g.: apprentice, dental health, financial considerations, etc.)

PATIENTS MEDICAL HISTORY

I consider my health to be *(please check one)* ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Do you or have you had any of the following? *please circle Y for yes or N for no.*

1. Y N Heart Disease
2. Y N Heart Murmur/Mitral Valve Prolapse
3. Y N Stroke
4. Y N Congenital Heart Lesions
5. Y N Rheumatic Fever
6. Y N Abnormal Blood Pressure
7. Y N Anemia
8. Y N Prolonged Bleeding Disorder
9. Y N Tuberculosis or Lung Disease
10. Y N Asthma
11. Y N Hay Fever
12. Y N Sinus Trouble
13. Y N Epilepsy/Seizures
14. Y N Ulcers
15. Y N Implants/Artificial Joints: ❑ Hip ❑ Knee ❑ Other
16. Y N I smoke or use tobacco. If yes, how much per day?_____ How many years?_____
17. Y N I have consumed alcohol within the last 24 hours.
18. Y N I usually take an antibiotic prior to dental treatment.
19. Y N Have you ever taken Fen-Phen or Redux?
20. Y N I have had major surgery: Year_____Type of operation:_____Year_____Type of operation:_____
22. Y N Liver Disease
23. Y N Jaundice
24. Y N Hepatitis Type____.
25. Y N Diabetes
26. Y N Excessive Urination and/or Thirst
27. Y N Infectious Mononucleosis (Mono)
28. Y N Herpes
29. Y N Arthritis
30. Y N Sexually Transmitted/Venereal Disease
31. Y N Kidney Disease
32. Y N Tumor or Malignancy
33. Y N Cancer/Chemotherapy
34. Y N Radiation Treatment
35. Y N History of Drug Addiction

Doctor Notes Only:

36. Y N AIDS
37. Y N Immune Suppressed Disorder
38. Y N Hearing Loss
39. Y N Fainting Spells
40. Y N Glaucoma
41. Y N History of Emotional or Nervous Disorders

WOMEN

42. Y N Are you taking birth control medication?
43. Y N Are you or could you be pregnant or nursing?

21. Y N, Do you have any other medical problem or medical history NOT listed on this form?_____

Are you allergic to any of the following?
Please circle Y for yes or N for no

44. Y N Aspirin
45. Y N Ibuprofen
46. Y N Sulfa Drugs/Sulfites/Sulfides
47. Y N Penicillin
48. Y N Codeine
49. Y N Latex, Metals, Plastics
50. Y N Local Anesthetics (Novocaine)
51. Y N Other Medications - Which ones?_____

Please list all medications you are currently taking:

Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Medicine_____Condition_____
Physician's Name_____Phone_____
Address_____Fax_____

In the event of an emergency please contact:

Name_____Relationship_____Phone_____
Name_____Relationship_____Phone_____

Initial medical/dental health reviewed by:

X_____/___/___ X_____/___/___
Doctor's Signature Date Patient's Signature Date

Periodic medical/dental health reviewed by:

X_____/___/___ X_____/___/___
Doctor's Signature Date If patient is a minor: Parent/Guardian's Signature Date

GETTING TO KNOW YOU AS OUR PATIENT

Informed Consent Form for General Dental Procedures

You the patient have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risks, and complications with your dentist and all of your questions are answered. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide your dentist with accurate information before, during and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Certain heart conditions may create a risk of serious or fatal complications. If you (or a minor patient) have a heart condition or heart murmur, advise your dentist immediately so s/he can consult with your physician if necessary.

The patient is an important part of the treatment team. In addition to complying with the instructions given to you by this office, it is important to report any problems or complications you experience so they can be addressed by your dentist.

If you are a woman on oral birth control medication you must consider the fact that antibiotics might make oral birth control less effective. Please consult with your physician before relying on oral birth control medication if your dentist prescribes, or if you are taking antibiotics.

As with all surgery, there are commonly known risks and potential complications associated with dental treatment. No one can guarantee the success of the recommended treatment, or that you will not experience a complication or less than optimal result. Even though many of these complications are rare, they can and do occur occasionally.

Some of the more commonly known risks and complications of treatment include, but are not limited to the following:

1. Pain, swelling, and discomfort after treatment.
2. Infection in need of medication, follow-up procedure or other treatment.
3. Temporary, or on rare occasion, permanent numbness, pain, tingling or altered sensation of the lip, face, chin, gums, and tongue along with possible loss of taste.
4. Damage to adjacent teeth, restorations or gums.
5. Possible deterioration of your condition which may result in tooth loss.
6. The need for replacement of restorations, implants or other appliances in the future.
7. An altered bite in need of adjustment.
8. Possible injury to the jaw joint and related structures requiring follow-up care and treatment, or consultation by a dental specialist.
9. Root tip, bone fragment or a piece of dental instrument may be left in your body, and may have to be removed at a later time if symptoms develop.
10. Jaw fracture.
11. If upper teeth are treated, there is a chance of a sinus infection or opening between the mouth and sinus cavity resulting in infection or the need for further treatment.
12. Allergic reaction to anesthetic or medication
13. Need for follow-up treatment, including surgery.

This form is intended to provide you with an overview of potential risks and complications. Do not sign this form or agree to treatment until you have read, understood, and accepted each paragraph stated above. Please discuss the potential benefits, risks, and complications of recommended treatment with your dentist. Be certain all of your concerns have been addressed to your satisfaction by your dentist before commencing treatment.

Patient Signature	Date	Witness	Date
Print Patient Name		Parent/Legal Guardian	Date

Appointment Policy

Your scheduled appointment is reserved specifically for you/your child. Any change in this appointment affects all of our patients. If a cancellation is unavoidable, please call our office at least 24 hours in advance so that we may give that time to another patient. **If one failed/missed appointment occurs, our office reserves the right to NOT schedule any subsequent appointments.** Also, if you arrive 10-15 minutes late for your appointment, you may be asked to reschedule for the next available appointment time. Again, please call at least 24 hours in advance if a cancellation is unavoidable so that we may give the appointment to another patient. Thank you.

Payment Policy

Payment in full is due at the time of service unless prior financial arrangements are made. We offer several payment options:

-Cash, Check and all major credit cards
-Care Credit

Our office is committed to helping patients maximize their insurance benefits. Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. As a service to our patients, we will be happy to manage all claim submission and follow up on your behalf. After your treatment services have been submitted, please allow up to 30 days to receive your direct reimbursement from your insurance company. If you have any questions or concerns feel free to give us a call at 320-229-2233.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____

AUTHORIZATION FOR RELEASE OF IDENTIFYING HEALTH INFORMATION

I authorize Welch Dental Care above to release health information identifying me (including if applicable, information about HIV infection or AIDS, information about substance abuse treatment, and information about mental health services) under the following terms and conditions:

1. Detailed description of the information to be released:
,2. To whom may the information be released (name(s) or class(es) of recipients):
3. The purpose(s) for the release (if the authorization is initiated by the individual, it is permissible to state *"at* the request of the individual" as the purpose, if desired by the individual):
4. Expiration date or event relating to the individual or purpose for the release:

It is completely your decision whether or not to sign this authorization form. We cannot refuse to treat you if you choose not to sign this authorization.

If you sign this authorization, you can revoke it later. The only exception is if we have already acted in reliance upon the authorization. If you want to revoke your authorization, send us a written or electronic note telling us that your authorization is revoked.

When your health information is disclosed as provided in this authorization, the recipient often has no legal duty to protect its confidentiality. In many cases, the recipient may re-disclose the information as he/she wishes. Sometimes, state or federal law changes this possibility.

(For marketing authorizations, include, as applicable: we will receive direct or indirect remuneration from a third party for disclosing your identifiable health information in accordance with this authorization.)

I HAVE READ AND UNDERSTAND THIS FORM. I AM SIGNING IT VOLUNTARILY. I AUTHORIZE THE DISCLOSURE OF MY HEALTH INFORMATION AS DESCRIBED IN THIS FORM.

Patient Signature:_____ Date:_____

If you are signing as a personal representative of the patient, describe your relationship to the patient and the source of your authority to sign this form:

Relationship to patient: _____ Print name: _____

_____

Patient Full Name: _____
Responsible Party Name: _____

I hereby authorize payment directly to Welch Dental Care/Dr. Courtney Welch of the dental benefits otherwise payable to me.

Welch Dental Care/Dr. Courtney Welch is authorized to provide any insurance company(s), claim administrators and consulting health care professionals, information will be used for the purpose of evaluating and administrating claims for benefits.

This authorization is valid for the term of coverage of the policy or contracts, enforce on this date only, or for two years, whichever is shorter.

I know I have a right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as its original.

Acknowledgement of Receipt:
I acknowledge that I received a copy and consented to the above of Welch Dental Care's privacy practices.

Signature: _____ Date:_____

Patient or Guardian Name (print): _____

For your information:

If you want more information about our privacy practices, call or visit the office contact person at the address or phone number shown below:

Dr. Courtney Welch DDS
151 19th Street S, Suite B
Sartell, MN 56377
Phone: 320-229-2233
Fax: 320-323-4748
Email: welchdentalcare@gmail.com