PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only
ID:

Address: | **Today's Date:** | **Date of Last Visit:** | **Date of Med. History:**

City State Zip: | **Email:**

Home Phone: | **Work Phone:** | **Cell Phone:** | **Birth Date:** | **Social Security No.:** | **Marital Status:**

Primary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Secondary Dental Guarantor: | **Home Phone:** | **Work Phone:** | **Cell Phone:**

Physician Name: | **Physician Phone:**

Pharmacy: | **Pharmacy Phone:**

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y	N	
☐	☐	Are you taking Birth Control Pills?
☐	☐	Are you pregnant? If Yes, # of weeks ☐
☐	☐	Are you nursing?

Please answer the following:

Y	N		
☐	☐	Do you smoke or use tobacco?	Height: ☐
For Office Use Only BP: ☐ Heart Rate: ☐			Weight: ☐

Y	N	Conditions
☐	☐	Vaccinated For Covid
☐	☐	Abnormal Bleeding
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Angina Pectoris
☐	☐	Anxiety / Nervous Problems
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Autism Spectrum Disorder
☐	☐	Bisphosphonate Therapy
☐	☐	Bruise Easily
☐	☐	Cancer- Chemotherapy
☐	☐	Colitis
☐	☐	Congenital Heart Defect
☐	☐	Coumadin/Plavix Medications
☐	☐	Dementia
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Fainting Spells

Y	N	Conditions
☐	☐	Fever Blisters
☐	☐	Frequent Headaches
☐	☐	HIV+ AIDS
☐	☐	Hearing Difficulty/Deaf
☐	☐	Heart Attack
☐	☐	Heart Surgery
☐	☐	Heart Transplant
☐	☐	Hemophilia
☐	☐	Hepatitis B
☐	☐	High Blood Pressure
☐	☐	High Cholesterol
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Mitral Valve Prolapse
☐	☐	Osteoporosis
☐	☐	Pace Maker
☐	☐	Pain In Jaw Joints
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Seizures

Y	N	Conditions
☐	☐	Sinus Problems
☐	☐	Sleep Apnea
☐	☐	Stroke
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Wheelchair

Y	N	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetics
☐	☐	Erythromycin
☐	☐	Jewelry
☐	☐	Latex
☐	☐	Metals
☐	☐	Penicillin
☐	☐	Tetracycline

Other

_____

_____

_____

Medications:

Y N

☐ ☐ **Is there any disease, condition, or problem that you think this office should know about that is not covered above? If yes, please describe below...**

Notes:

Signature: _____ **Date:** _____

(If Under 18, Parent or Guardian Signature Required)

DRS. WARD AND VAUDRY OFFICE POLICIES

APPOINTMENTS:

We utilize software to remind patients about their appointments as a courtesy. Please update your phone and email information to ensure you receive these reminders.

Please provide 48 hours advance notice for changes to your appointment, or a missed appointment fee may be assessed ($75).

We strive to be prompt for appointments and therefore may ask patients who arrive over 15 minutes late to reschedule.

Please refrain from talking or texting on your cell phone while in the treatment area. Parents of school aged children are asked to remain in the waiting room.

Drs. Ward and Vaudry will select the best material for your restoration/filling considering conserving tooth structure, location, durability and function. The material selected is based on Drs. Ward and Vaudry's professional opinion and not insurance coverage. Some materials may result in a higher patient cost.

We may utilize intra-oral photos to aid with lab communication and consultation with other providers. Photos will NOT be used on our website or social media.

EXAMS / RADIOGRAPHS / DIAGNOSTIC TESTS

Our office provides comprehensive / preventive dental treatment and all patients receive an examination at every cleaning visit.Patients who have dental insurance with a frequency limitation will incur a fee for their examination.Our office does not provide a cleaning without an examination.

Refusal of diagnostic tests (including radiographs and examinations) will result in our inability to provide treatment.Patients who refuse radiographs and/or examinations will be dismissed from the practice.

ACCOUNTING

Payment is requested as treatment is rendered. Accounts with balances over 60 days past due will be assigned for collections. There is a $40 fee for returned checks. Balances over 30 days will accrue late fees.

Care Credit financing is available for patients. Payment is due as services are rendered.

HIPPA:

Our office follows HIPAA guidelines.

OTHER:

Patients who are 24 or more months overdue for their preventative dental maintenance (cleaning and examination) will be considered inactive.

I have read the above. I understand I am financially responsible for all charges.

Patient Name: _____ Date: _____

Signature: _____ (If patient is under 18 see below)

If Under 18: *I understand I am financially responsible for all charges on the above named patient.*

Parent / Legal Guardian: _____ Date: _____

Signature: _____

DRS WARD AND VAUDRY GENERAL CONSENT FORM

MEDICAL HISTORY:
it is important you provide all information about your medical history to our office. Please provide us with a current list of medications (prescription, over the counter and herbal) and allergies.

RADIOGRAPHS (x-rays):
I understand diagnostic radiographs provide valuable information of areas that can not be examined otherwise. Our office takes the minimum radiographs needed to allow us to do a thorough exam on each patient. All patients will receive the appropriate type and number following the FDA guidelines. I understand radiographs are an integral part of my examination. I understand if I refuse radiographs Drs Ward and Vaudry will not be able to treat me.

RESTORATIONS/CROWNS:
I understand care must be exercised after receiving a filling/crown to avoid damage and breakage. I understand more treatment may be required based on the conditions found during the appointment or the tooth response to treatment. I understand sensitivity may occur after a newly placed filling or crown.

CHANGES TO TREATMENT PLAN:
I understand that during treatment it may be necessary to add, remove or change procedures or recommendations.

COMPLICATIONS:
I understand there may be risks and complications related to dental treatment. These may include (but not limited to): swelling, sensitivity, bleeding, pain, infection, numbness (may be permanent), and or need for additional treatment. Drs. Ward and Vaudry do their best to minimize complications and decrease risks.

REFERRALS:
Drs. Ward and Vaudry may refer some advanced dental procedures to specialists who have additional training in the field (root canals, orthodontics, some oral surgery).

CONSENT:
I understand the longevity and success of dental treatment depends on my cooperation with oral hygiene, compliance and follow through with recommendations. I consent for Drs Ward and Vaudry to provide exam, diagnosis and treatment plan at my appointment, after which recommended treatment will be discussed.

MINORS (UNDER 18 ONLY)

I give consent for my child to receive dental treatment with Drs. Ward and Vaudry.

I affirm I am the parent / legal guardian. If I am unable to accompany my child I give permission for the individuals named below to escort my child for dental treatment.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If child is over 13 please check one:

( ) I give permission for my child to present for their dental cleaning and examination unaccompanied by an adult. No invasive treatment will be performed unless I am reached by telephone.

( ) Although my child is over 13, I will be present for all appointments.

Name Printed: _____ Date: _____

Signature: _____

FINANCIAL POLICY AND RELEASE BENEFITS FOR PATIENTS WITH INSURANCE

Dental insurance is a contract between you and your insurance company. It is your responsibility to understand the extent and limits of your coverage, and to provide our staff with accurate information to process your claim efficiently (i.e. insurance company address, phone number, etc.). It is not our place to enter into disputes between you and your insurance company regarding deductibles, copayments, eligibility dates, etc. other than to provide factual information. We participate with BCBS and Delta Dental. For other companies we are considered out of network, however, as a courtesy, we will assist with processing of your claim.

Dental insurance helps to defray the cost of dental treatment but is not all-inclusive. Plans contain deductibles, co-payments, maximums and have contractual limitations. Patients are responsible for their account balance after the insurance has made its contribution.

Pretreatment estimates are provided as a courtesy. Actual benefits may vary once a claim is filed depending on materials used, insurance contract, and other restrictions.

RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize this office to release to your benefit program or its representative any information including the diagnosis and the records of any treatment or examination rendered to me. I authorize, if applicable, payment to be sent to this office.

I AGREE TO BE FINANCIALLY RESPONSIBLE FOR SERVICES RENDERED

Patient Name: _____

Signature of Insured / Responsible Party: _____

Printed name: _____

DATE: _____

Other family members this applies to:

NAME: _____

NAME: _____

NAME:_____

NAME:_____