Wood Implants and Periodontics
Rob A. Wood DMD MS
77 s. 700 e. Ste 260
Salt Lake City, Utah 84102

Patient Information

Date: _____

Name_____Preferred Name_____

Email_____

Birthdate_____ Soc. Sec#____-____-_____

Address_____ City_____ State____ Zip____

Home #____-____-____ Work#____-____-____ Cell # ____-____-____

Insurance Information

Primary Insurance:
Name of Insured_____
Birthdate_____ Soc. Sec # ____-____-____
Name of employer_____ Insurance Company_____
Tel# _____ Group# _____ Policy/ ID# _____
Insurance Co.
Address_____

Secondary Insurance:
Name of Insured_____
Birthdate_____ Soc. Sec # ____-____-____
Name of employer_____ Insurance Company_____
Tel# _____ Group# _____ Policy/ ID# _____
Insurance Co.
Address_____

Medical History

Physician _____ Physician phone # _____ Date of last exam_____

Are you under any medical treatment now? Y N
Have you been hospitalized for any reason in the last 5 years? Y N If yes, please explain_____
_____
Are you taking any medication(s) including non-prescription medicine? Y N If yes, please list_____
_____
Have you ever taken Phen-Fen / Redux (Weight loss drug)? Y N Have you ever taken Bisphosphonates (Fosamax, Boniva etc.)? Y N
Do you use tobacco? Y N How much? _____ Do you use controlled substances? Y N If yes, please list_____

Are you allergic to or have you ever had any reactions to the following:

Local Anesthetics (e.g. Novocaine)	Y N	Are you pregnant or think you may be pregnant?	Y N
Penicillin or any other Antibiotics	Y N	Are you nursing?	Y N
Sulfa Drugs	Y N	Are you using oral contraceptives?	Y N
Barbiturates (Sleeping pills)	Y N	Are you menopausal / post menopausal?	Y N
Sedatives	Y N		
Iodine	Y N	**Do you have any of the following:**	
Aspirin	Y N	AIDS / HIV	Y N
Any Metals (e.g. Nickel, Mercury etc)	Y N	Hepatitis A B C	Y N
Latex Rubber	Y N	Sexually Transmitted Disease	Y N
Other _____		Herpes	Y N

Alcoholism	Y N	Glaucoma	Y N	Liver Disease	Y N
Asthma	Y N	Hay Fever/Allergies	Y N	Mitral Valve Prolapse	Y N
Angina	Y N	Heart Attack	Y N	Prostate Troubles	Y N
Arthritis	Y N	Heart Disease	Y N	Psychotherapy	Y N
Cardiac Pacemaker	Y N	Heart Murmur	Y N	Rheumatic Fever	Y N
Cancer	Y N	Heart Trouble	Y N	Radiation Therapy	Y N
Chest Pains	Y N	Heart Valve Replacement	Y N	Recent Weight Loss	Y N
Diabetes:	Y N	Heart or Blood Vessel Surgery	Y N	Respiratory Problems	Y N
(type I)	Y N	High Blood Pressure	Y N	Swollen Ankles	Y..N
(type II)	Y N	Joint Replacement (knee,hip etc.)	Y N	Stomach Trouble /Ulcers	Y N
Epilepsy/Seizures	Y N	Kidney Disease	Y N	Stroke	Y N
Easily Winded	Y N	Low Blood Pressure	Y N	Thyroid Problem	Y N
Emphysema	Y N	Leukemia	Y N	Tuberculosis	Y N
Fainting/Seizures	Y N	Other_____			

Dental History General DDS _____ How long have you been a patient with current dentist? _____

DO YOU FEAR DENTAL TREATMENT?	**Y N**
Do your gums bleed while brushing or flossing?	Y N
Do you have pain in any of your teeth?	Y N
Do you have any sores or lumps in or near your mouth?	Y N
Have you ever had any head, neck or jaw injuries?	Y N
Have you ever had any difficult extractions?	Y N
Have you ever experienced prolonged bleeding?	Y N
Do you wear dentures or partials (e.g. removable teeth)	Y N
Have you ever had orthodontic treatment (e.g. braces)	Y N

Are your teeth sensitive to any of the following:
Hot or cold Y N Sweet or sour Y N

Have you experienced any of the following TMJ problems?	
Clicking	Y N
Problems chewing	Y N
Difficulty opening or closing	Y N
Changes in your bite	Y N
Clenching or grinding	Y N
Frequent headaches	Y N
Bruising	Y N
Frequent biting of lips or cheeks	Y N

Other _____
_____

Financial Policy & Authorizations
Wood Implants and Periodontics

- As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patient for the costs incurred in their care and the financial responsibility on the part of each patient must be determined before treatment.

- All emergency dental services or any dental services performed without previous financial arrangements must be paid for at the time services are performed. We accept MasterCard, Visa, American Express, Discover, cash, and checks. If you are in need of an extended finance option, we work with CareCredit, which offers short term interest free programs or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Ask for details.

- If you have a Dental Plan please know that it is designed to help you pay for a portion of the cost of your dental care. Therefore, patients who have dental insurance should understand that all dental services provided are charged directly to the patient and that he or she is personally responsible for payment of all dental services. Dental benefit plans will never pay for all of your dental care, it is only meant to assist you. Our office will prepare insurance forms and assist in obtaining payment from your insurance company on your behalf and will credit any such payments to your account. Please understand our dental office cannot render services on the assumption that our charges will be paid by your insurance company.

- Insurance eligibility and benefits quoted are not a guarantee, they are subject to change. We will provide you with an estimate of your co-payments and deductible based on your insurance coverage which is payable at the time of your visit. The ESTIMATE IS NOT A GUARANTEE of the final amount of benefits to be paid by your insurance company. The final amount of benefits to be paid will be determined by your insurance company only after they receive the dental claim. If you have any questions regarding your dental benefits please contact your employer or insurance company directly.

- The amount your plan pays is determined by the agreement negotiated by your employer with the insurer and by how much your employer contributes to the plan.

- I further agree to pay for all services rendered regardless of anticipated insurance benefits within 30 days of the date of service, if no other financial arrangements have been made.

- I also do herby agree to pay any and all costs of collections (totaling 40% of the unpaid balance) for unpaid balances due on my account after 90 days, including additional secretarial and bookkeeping expenses, as well as attorney's fees with or without suit.

- I authorize Wood Implants and Periodontics to release any information required to process my dental claims and request that my insurance company pay the doctor directly.

- **I have read and understand the above Financial Policy and Authorizations. I acknowledge receipt of this office's Notice of Privacy Practices.**

▶ _____ Date:_____ Relationship to Patient:_____
Signature of patient, parent or legal guardian