Wesley Nelson, DDS

PATIENT MEDICAL HISTORY

Name ______ Age ______ Birthdate ______ Marital Status ______

Address ______ City ______ Zip ______ Phone ______

Patient Employed By ______ Cell. Phone ______ Email ______

Occupation ______ Business Phone ______

Name of Spouse ______ Spouse's Occupation ______

Spouse Employed by ______ Business Phone ______

Spouse Business Address ______ City ______ Zip ______

In Case of Emergency Contact: ______ Phone ______ City ______

Name of Physician ______ Phone ______ Date of Last Exam ______

Reason for this visit ______ Patient Referred By ______

Dental Insurance Company ______ Social Security # ______

Dental problems are produced by a combination of many complex elements. Though some of the following questions may seem unrelated to your dental condition, they are all associated with proper management of your oral health.

		Yes	No
1.	Are you under a physician's care at present?	☐	☐
2.	Are you taking any medicine or vitamins now?	☐	☐
	If yes, please specify name(s): (types, amount, frequency) ______		
3.	Have you ever been seriously ill?	☐	☐
4.	Have you ever been told to premedicate with antibiotics before dental treatment	☐	☐
5.	Do you have or have you ever had any of the following? *(Date if Applicable)*		

	Yes	No		Yes	No
Rheumatic fever	☐	☐	Autoimmune Disease, Arthritis, Lupus	☐	☐
Heart Trouble, Prolapse or Murmur	☐	☐	Kidney disease	☐	☐
Heart Valve Replacements	☐	☐	Respiratory problems	☐	☐
Diabetes	☐	☐	AIDS, HIV Positive	☐	☐
Hepatitis, Jaundice, or Liver disease	☐	☐	Stroke	☐	☐
Venereal disease	☐	☐	Asthma	☐	☐
Leukemia	☐	☐	High or low blood pressure	☐	☐
Artificial joints, Pins, Rods, Plates	☐	☐	Seizures	☐	☐
Cancer	☐	☐	Substance abuse problems	☐	☐
Eating Disorders	☐	☐	History of Psychological Counselling	☐	☐

		Yes	No
6.	Have you ever had an allergic reaction to any of the following? If so, please check ☐ Aspirin ☐ Penicillin ☐ Other Medicine or Substance?	☐	☐
7.	Have you ever had an injury to your face or jaws?	☐	☐
8.	Have you ever had surgery or radiation therapy for a tumor, growth or skin disease?	☐	☐
9.	Do you have chest pain on exertion or shortness of breath?	☐	☐
10.	Have you ever had prolonged bleeding following a cut or extraction of a tooth?	☐	☐
11.	Have you ever had blood transfusions?	☐	☐
12.	Do you currently or have you ever used tobacco products	☐	☐
	If yes, please specify: ______		
13.	Do you currently or ever consume alcoholic beverages?	☐	☐
	If yes, please specify: ______		
14.	Do you have any disease, condition or problem not listed above that you think I should know about?	☐	☐
	If yes, please specify: ______		
15.	Have you ever experienced an unusual reaction to a dental injection (novocaine)?	☐	☐
16.	Have you ever had periodontal treatment	☐	☐
17.	Women, are you pregnant?	☐	☐
	Are you taking birth control pills?	☐	☐

To the best of my knowledge, all of the preceding answers are correct. If I have any changes in my health status or any changes in my medicines, I shall inform the dentist and staff at the next appointment without fail.

X ______ DATE ______

PATIENT SIGNATURE (PARENT OR GUARDIAN)

REVIEWED BY DOCTOR ______ DATE ______

MEDICAL UPDATES

I have read my MEDICAL HISTORY dated ______ and confirm that it adequately states past and present conditions

DATE	EXCEPTIONS		PATIENT'S SIGNATURE	REVIEWED BY
______	______	None ☐	______	Dr. ______
______	______	None ☐	______	Dr. ______
______	______	None ☐	______	Dr. ______
______	______	None ☐	______	Dr. ______
______	______	None ☐	______	Dr. ______

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) ____'s dental needs.

Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made.

Patient______________________________Date__________Witness____________________________

Parent or Responsible Party____________________Relationship to Patient____________________

Wesley Nelson, DDS

5770 WILES RD | CORAL SPRINGS FL, 33067 | (954) 255-5166

Written Financial Policy

Thank you for choosing Wesley Nelson, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of that mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Visa, MasterCard or Discover Card

  We offer a 5% courtesy accounting adjustment to patients who pay for their treatment with cash prior to completion of care for treatment plans of $1000 or more.

- Convenient Monthly Payment Options[1] from CareCredit Healthcare Credit Card
  - Allow you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Wesley Nelson, DDS requires payment at the beginning of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.[2]

A fee of $25 is charged for patients who miss or cancel more than 2 times in a calendar year without 48-hour notice.

Wesley Nelson, DDS charges $30 for retureened checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

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____

Patient, Parent or Guardian Signature Date

____

Patient Name (Please Print)

[1]Subject to credit approval

[2]However, if we do not receive payment from your insurance carrier within 90 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

Wesley Nelson, DDS

PHOTO RELEASE FORM

SUBJECT: DENTAL PHOTOGRAPHS

LOCATION: WESLEY NELSON, DDS – DENTAL OFFICE, CORAL SPRINGS, FL

I GRANT TO **WESLEY NELSON, DDS, IT'S REPRESENTATIVES AND EMPLOYEES** THE RIGHT TO TAKE PHOTOGRAPHS OF MY FACE/AND TEETH, BEFORE, DURING, AND AFTER TREATMENT.

I CONSENT TO ALLOW THE PHOTOGRAPHS TO BE USED FOR THE FOLLOWING:-

- DENTAL RECORD KEEPING
- DENTAL EDUCATION

I FURTHER UNDERSTAND THAT MY NAME AND OTHER IDENTIFYING INFORMATION WILL BE KEPT CONFIDENTIAL.

I HAVE READ AND UNDERSTAND THE ABOVE :

SIGNATURE ____

PRINTED NAME ____

ADDRESS ____

DATE ____________________

SIGNATURE OF PARENT OR GUARDIAN ____________________________

NOTICE OF PRIVACY PRACTICE

We are required by law to maintain the privacy of your health information and to show you this Notice about our practices and your rights concerning your health information.

In addition to our use of your health information for treatment, payment or healthcare operations or providers, only you may give us written revocable authorization to use your health information or to disclose it to anyone for any purpose.

We may disclose your health information to the following person/persons without your written consent:

____

____

We will use our professional judgment to disclose only health information that is directly relevant and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other forms of health information. We will not use your health information for marketing communications without your written authorization. We may use or disclose your health information to provide you with appointment reminders (such as voicemail, email, postcards or letters).

You have the right to look at or get copies of your health information as long as you sign a records release.

(INITIAL)________

You have the right to request that we place additional restrictions on our use or disclosure of your health information.

(INITIAL)________

You have the right to request that we amend your health information.

(INITIAL) ________

You agree to allow us to send referrals to specialists & Labs which may include personal health history and your x-rays.

(INITIAL)________

You give us permission to call in any neccessary prescriptions and share your personal health history with the Pharmacist.

(INITIAL)________

You agree to us sending electronic and paper claims to your insurance company, which may include personal health history and x-rays

(INITIAL) ________

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information, you may complain to the U.S.Department of Health and Human Services or us. We support your right to the privacy of your health information and will not retaliate in any way should you do so.

PATIENT ACKOWLEDGMENT

My signature below acknowledges that I have read and understand the privacy practices of the office.

PRINT NAME: ____

____________________________ ________________

Signature Date