Welcome to Wedgwood Smiles!

We are glad you have decided to join our dental family. We look forward to providing you with excellent dental care. Dr. Cruz's approach to dentistry is conservative and you will always be given all of your options for dental care. Our goal is to give patients the dental care we would give our own family members.

*Disclaimer: Any Complementary services will not be combined with any other offer or discounts. Other restrictions may apply.
Please note: There will be a fee for transferring the records of any complementary services.

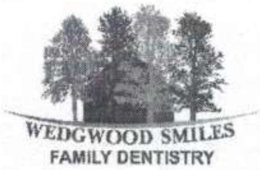
I understand and acknowledge this disclaimer:

____

Name of Patient or Personal Representative ____________________________ Date ____________

Signature____________________________

Description of personal representative's Authority____________________________



Acknowledgement of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Wedgwood Smiles. The Statement of Privacy Practices describes the type of uses and disclosures of my **protected health information** that might occur in my treatment, payment for services, or in the performance of office health care operations. The statement of Privacy Practices also describes my right and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Wedgwood Smiles reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate Family _____Y _____N

Other (please specify) _____Y _____N

____

Name of Patient or Personal Representative ______________________________ Date ______________

Signature ______________________________

Description of personal representative's Authority ____________________________________

Financial & Appointment Policies

Welcome, we are happy to have you as our patient and look forward to offering you and your family the finest dental care available. Before treatment is performed, we will discuss treatment and financial options.
All payments are due at the day of service. To make our services comfortable and affordable we accept: **cash, checks, Visa, MasterCard, HSA, FHSA, LendingClub and CareCredit (financing)**

All patients will be given ONE the following courtesy discounts for dental services, when paying in full for service.
-5% Senior Discount, Ages 65 or older.
- 6% Discount for **Advanced Payment** when you schedule any recommended treatment. Please ask for details, Advanced Payment discounts will **not** be applied when paying with **LendingClub or CareCredit.**

Please ask for help at the front desk for explanation on our discounts. Discounts are at the discretion of our dental office and could be changed or cancelled by Wedgwood Smiles with or without notice.

Insurance: As a courtesy to our patients, we are happy to submit claims to your insurance company. Recognizing that your dental coverage is a relationship between you and your insurance company, we will do everything we can to accurately estimate any benefits allowable on your plan but cannot guarantee what your insurance will ultimately pay on your behalf. We ask that estimated fees not covered by your insurance be paid at the time of service and that all services are paid within thirty (30) days of treatment regardless of whether you insurance benefits have been received.

Billing: Please pay any balance in full within 15 days of received statement. First statement is sent at no charge, additional statements will reflect a $12.00 administration fee. Balances over 30 days could be sent to collections unless prior arrangements have been made between guarantor and Wedgwood Smiles. Guarantor agrees to be liable for all collection fees.

I acknowledge that I am financially responsible for the payment of all procedures performed in this office regardless of insurance coverage.

Appointments are reserved exclusively for you. As a benefit to you, our valued patient, we may offer to move your appointment to an earlier time if opening arise. There is a **$50.00 charge** for any broken appointments. Broken appointments are considered those that are missed (no-show) and cancelled with less than **2 business days, advance notice**. We reserve the right to refuse dental services for non- compliant patients. I have read and understand this financial policy.

Patient Name____

Signature of Patient/Guardian______________________________ Date: ______________

Consent for treatment

I consent to all procedures necessary for my dental diagnosis and care, these may include, but are not limited to; the use of x-rays, local anesthesia, medications and/or any other diagnostic/restorative procedures. I, the undersigned patient, hereby authorize Wedgwood Smiles to perform the procedure(s) or course(s) of treatment. I authorize Dr. Cesar Cruz and any other qualified assistants or medical professional to perform the procedure(s) or treatment(s). I also give my consent for dentist and staff to administer any needed medicine and to perform any compulsory life-saving procedure if it was the case.

I have read and understand the information contained within this form. Questions and answers have been addressed.

Signature of Patient/Guardian______________________________ **Date**______________________

REV/03/01/2018

WEDGEWOOD SMILES

PATIENT GENERAL INFORMATION

Date ____________________________

Name ____ Date of Birth __________________

If a child, parents name ____

Address ____ City ____________________ State ______ Zip ________

Home phone _________________________ Work phone _______________________

Cell phone ___________________________

Social Security # ________________________ Email ____
(If for a minor, please provide a parent # SSN)

Employer __________________________________ Occupation ____

Name of responsible party (if a minor) ____ Phone ____________________

Responsible party address (if different from above) ____

Emergency contact ____ Phone # _________________________

Relationship to patient ____

Whom may we thank for referring you? ____

INSURANCE INFORMATION **PLEASE PROVIDE A COPY OF YOUR DENTAL INSURANCE CARD**

Subscriber name ____________________________________ Subscriber DOB _____________________________

Subscriber SSN _Please present at the office Subscriber ID ______________________________________

Insurance company _____________________________ Group # ____

Insurance phone #: ____

Subscriber Employer __________________________ Relationship to patient ________________________________

Do you have a secondary dental plan? ____________

Authorization

The above questions have been accurately answered. I authorize and request my insurance company to pay directly to the dentist. I understand my dental insurance may pay less then the actual bill for services. I agree to be responsible for payment of all services made on my behalf or my dependants.

____ ____

Signature Please print name

PATIENT MEDICAL HISTORY

DATE ______________________ PATIENT PHONE# ______________________

PATIENT NAME ______________________________ DOB: ____________

PHYSICIAN'S NAME ______________________ PHYSICIAN'S PHONE# __________

EMERGENCY CONTACT ______________________ PHONE# ______________

MEDICATIONS: ______________________ PURPOSE: ______________________

	YES	NO
1. Are you presently under the care of a Physician?	____	____
2. Do you take antibiotic medication before dental treatment?	____	____
3. Has there been any change in your health in the past year?	____	____

If ***YES***, explain: ____

4. Have you been hospitalized for any surgical operation or serious illness with in the last 5 years?
   Yes _____ or NO _____ If yes, please explain: ______________________________

5. Do you have difficulty breathing while sleeping? Yes____ No____
6. Do you snore? Has anyone told you that you snore? Yes____ No____
7. Have you ever been treated for any of the following conditions?

Circle for YES

Heart murmur	Diabetes	Tuberculosis
Rheumatic Fever	Swollen ankles	Radiation therapy
Mitral Valve Prolapse	Leukemia	Glaucoma
Artificial Heart Valve	Epilepsy/Convulsions	Liver disease
Heart Surgery	Kidney disease	Respiratory problems
Heart Disease	AIDS / HIV	Heart trouble
Angina (Chest pains)	Thyroid problems	Recent weight loss/gain?
Heart Attack	Anemia	Frequently Tired?
Stroke	Emphysema	Sleep Apnea
Pacemaker	Arthritis	If so, do you wear a CPAP? Y N
Cancer	Hepatitis / Jaundice	Other ______________
Joint replacement	Sexually transmitted disease	
High Blood Pressure	Stomach troubles / ulcers	
Low Blood Pressure	Chest pains	
Fainting / seizures	Easily winded	
Asthma	Hay fever / allergies	

Cont' on next page

8. Have you ever had an **allergic reaction** to the following?
Circle for YES

Local anesthetic Sulfa Aspirin Penicillin Barbiturates Sedatives Iodine
Latex rubber
Any metals ______________________________
Other antibiotics ______________________________
Other ______________________________

9. Women only:	Yes	No
a. Are you pregnant or think you may be pregnant?	____	____
b. Are you nursing?	____	____
c. Are you taking oral contraceptives?	____	____
10. General information		
a. Are you wearing contact lenses?	____	____
b. Do you have a persistent cough or throat clearing associated with a known illness for more than 3 weeks?	____	____
c. Do you use tobacco? If yes, how often? ________	____	____
d. Do you use controlled substances?	____	____
e. Have you ever taken Fen-Phen/Redux?	____	____
f. Have you taken Fosamax, Boniva, Actonel or any Cancer medication containing bisphosphonates?	____	____
g. Have you taken Viagra, Revatio, Cialis, or Levitria **in the last 24 hours**?	____	____

AUTHORIZATION AND RELEASE

I certify that I have read and understood the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release and information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners.

X ______________________________ Signature

______________________________ Please print name

__________ Date

______________________________ Relationship to patient if not signed by patient

______________________________ Dr. Signature/Date

Cont' on next page

WEDGWOOD SMILES

PATIENT DENTAL HISTORY

Date ____________________

Patient name ____

Date of birth ____

DENTAL HISTORY

	Yes	No
a. Do your gums bleed while flossing?	______	_____
b. Are your teeth sensitive to hot or cold liquid/foods?	______	_____
c. Are your teeth sensitive to sweets or sour liquids/foods?	______	_____
d. Do you have any sores or lumps in or near your mouth?	______	_____
e. Have you had any head, neck, or jaw injuries?	______	_____
f. Have ever experienced any of the following problems with your jaw?		
1. Clicking	______	_____
2. Pain in joint, ear, or side of face?	______	_____
3. Difficulty in opening or closing?	______	_____
4. Difficulty in chewing?	______	_____
g. Do you have frequent headaches?	______	_____
h. Do you clench or grind your teeth?	______	_____
i. Do you bite your lips or cheeks frequently?	______	_____
j. Have you ever had any difficult extractions in the past?	______	_____
k. Have you ever had prolonged bleeding following an extraction?	______	_____
l. Have you ever had difficulty getting numb?	______	_____
m. Do you wear dentures or partials? If yes, estimated date of placement ______________	______	_____
n. Have you had any orthodontic treatment?	_____	_____
o. Do your wear a night guard?	_____	_____
p. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	_____	_____
q. Do you like your smile?	______	_____
r. Is there anything regarding your dental care you would like us to know?	______	_____

Explain: ____________________________________

____

Initials:_______ Date:_______

Initials:_______ Date:_______

Initials:_______ Date:_______