Welcome

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

1 ABOUT YOU

Today's Date: _____

E-Mail Address: _____

Name: _____
Last First Mi Mr Mrs Ms Dr

I prefer to be called: _____ ☐ Male ☐ Female

Birthdate: ___/___/___ Age: ____ SS#: _____

Home Address: _____
Apt/Condo #

_____
City State Zip

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Hm #: (____)_____ Cell #: _____

Wk #: (____)_____ Ext: ____ DL #: _____

Employer: _____

Employer's Address: _____

_____
City State Zip

How long there? _____ Occupation: _____

Where & when are best times to reach you? _____

Who may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

2 SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

Contact #: (____)_____ Ext:____ SS #: _____

Birthdate: ___/___/___ DL #: _____

Person responsible for account: _____

Wk #: (____)_____ Ext: ____ Hm #: (____)_____

Billing Address: _____

Relationship: _____ SS #: _____

Employer: _____ DL #: _____

3 INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____) _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ___/___/___ Insured's ID #: _____

Insured's Employer: _____

Employer's Address: _____

Neighbor or relative not living with you

His / Her Name: _____ Relation: _____

Wk #: (____)_____ Hm #: (____)_____

Address: _____

_____
City State Zip

4 MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: (____)_____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

CONTINUED ON BACK

4 MEDICAL HISTORY continued

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

Have you had any metal rods, pins or implants? ☐ Yes ☐ No

Are you taking any prescription / over-the-counter or herbal supplemental drugs? ☐ Yes ☐ No

Please list each one: _____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

Have you been told that you snore or hold your breath while sleeping or wake up gasping for breath? ☐ Yes ☐ No

For Women: Are you using a prescribed method of birth control? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems

Y	N	Abnormal Bleeding	Y	N	Herpes / Fever Blisters
Y	N	Alcohol / Drug Abuse	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV+ / AIDS
Y	N	Arthritis	Y	N	Hospitalized for Any Reason
Y	N	Artificial Bones / Joints / Valves	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Liver Disease
Y	N	Blood Transfusion	Y	N	Low Blood Pressure
Y	N	Cancer/Chemotherapy	Y	N	Lupus
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Osteoporosis / Paget's Disease
Y	N	Diabetes	Y	N	Pacemaker
Y	N	Difficulty Breathing	Y	N	Psychiatric Treatment
Y	N	Emphysema	Y	N	Radiation Treatment
Y	N	Epilepsy	Y	N	Rheumatic / Scarlet Fever
Y	N	Fainting Spells	Y	N	Seizures
Y	N	Frequent Headaches	Y	N	Shingles
Y	N	Glaucoma	Y	N	Sickle Cell Disease / Traits
Y	N	Hay Fever	Y	N	Sinus Problems
Y	N	Heart Attack	Y	N	Stroke
Y	N	Heart Murmur	Y	N	Thyroid Problems
Y	N	Heart Surgery	Y	N	Tuberculosis (TB)
Y	N	Hemophilia	Y	N	Ulcers
Y	N	Hepatitis	Y	N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Tetracycline
Y	N	Codeine	Y	N	Latex	Y	N	Other
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs/materials that you are allergic to: _____

_____

5 DENTAL HISTORY

Why have you come to the dentist today? _____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No

Have you ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you have fears about going to the dentist? ☐ Yes ☐ No

Have you ever had gum treatment? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Y ☐ N Do your gums ever bleed? ☐ Y ☐ N

How many times a week do you floss? _____ a day do you brush? _____

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

How long do you use a toothbrush before replacing it? _____

Are your teeth sensitive to heat, cold, or anything else? _____

Have you lost any teeth? ☐ Yes ☐ No If yes, why? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I have received a copy of this office's Notice of Privacy Practices.

_____

Signature Date

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

_____

Signature Date

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

_____

MEDICAL HISTORY UPDATE

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

I have read my medical history dated _____ and confirmed that it states past and present medical conditions. _____
Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVATE PRACTICES

PATIENT NAME: _____ **DATE OF BIRTH:** _____

I HAVE RECEIVED EITHER A PAPER OR AN ELECTRONIC COPY OF THE HIPPA NOTICE OF PRIVATE PRACTICES FOR CLEAR WAVE DENTAL. I UNDERSTAND THAT I AM ENTITLE TO RECEIVE A PAPER COPY OF THE NOTICE IF I ASK FOR IT, EVEN IF I HAVE ALREADY AGREED TO RECEIVED ONLY AND ELECTRONIC COPY.

_____ **DATE SIGNED:** _____

SIGNATURE OF PATIENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

IF APPLICABLE:

PATIENT'S GUARDIAN OR REPRESENTATIVE'S NAME: _____

PHONE NUMBER: _____ **REPRESENTATIVE'S RELATION TO PATIENT:** _____

REPRESENTATIVE'S ADDRESS: _____

PERMISSION TO DISCUSS TREATMENT OR BILLING INFORMATION

I GIVE PERMISSION TO DISCUSS MY TREATMENT AND/OR BILLING INFORMATION WITH:

NAME: _____ **RELATIONSHIP TO THE PATIENT:** _____

FINANCIAL AND PAYMENT POLICY

ALL ACCOUNTS ARE DUE AND PAYABLE AT THE TIME OF SERVICE IF A PROCEDURE REQUIRES MULTIPLE APPOINTMENTS; PAYMENT IS REQUIRED IN FULL AT THE FIRST APPOINTMENT.

PAYMENT OPTIONS:

CASH, MASTER CARD, VISA, DISCOVER, AMEX, CARE CREDIT AND GREEN SKY.

PATIENTS WITH INSURANCE:

THE PATIENT IS RESPONSIBLE FOR THE ESTIMATE NON-COVERED PORTION, PROCEDURE AND/OR DEDUCTIBLE AT THE TIME OF SERVICE. IF THE INSURANCE COMPANY DOES NOT PAY AFTER 60 DAYS, WE WILL BILL YOU DIRECTLY THE FULL BALANCE.

PATIENT SIGNATURE: _____ **DATE SIGNED:** _____

Electronic Communications Consent

We know our patients lead busy lives and are proud to provide electronic communications as an added convenience to our patients. With our electronic communications platforms our patients have the ability to:

- Complete and Submit Patient Intake Forms
- Request and Confirm Appointment Times
- Receive Appointment Reminders
- Receive Promotional Offers and/or Specials
- Submit Patient Satisfaction Surveys
- Refer your Friends and Family

Electronic communications may include, but are not limited to email, text and instant messaging and/or any online communications. You may choose to discontinue your electronic communications participation at any time by clicking the "**Unsubscribe**" link found at the bottom of any email, and/or by replying "**STOP**" to any text message received *(standard messaging and data rates may apply).*

If you wish to receive electronic communications, please provide us with your email address and/or mobile telephone number *(standard messaging and data rates may apply).*

_____ _____

Email Address Mobile Number

Standard Text Message Commands

P: Request a telephone call back
C: Confirm Appointment
STOP: Stop all text messaging from our office.

By signing below you are agreeing to receive electronic communications from Clear Wave Dental.

_____

Patient Signature

By signing below you acknowledge that it is the patient's responsibility to opt out of receiving electronic communications from Clear Wave Dental and/or any of its affiliates and that Clear Wave Dental is not responsible for any errors occurring through the electronic opt out process.

_____

Patient Signature

Third Party Communications

Our goal is to provide you with excellent dental care and overall ease of service and satisfaction. In the event we need to disclose any patient health information (PHI) to a third party and/or affiliate outside of Clear Wave Dental for the administration of your dental and/or health benefits, it will be in accordance with HIPAA. All third parties and/or affiliates outside of Clear Wave Dental are contracted by law to protect patient health information (PHI) confidentiality. Clear Wave Dental and any third party and/or affiliate contracted by Clear Wave Dental do not sell, share or rent our users' personally identifiable information unless required by law; do not send any e-mail or other electronic communications without your permission; and do not send spam.

By signing below you grant Clear Wave Dental permission to share any and all pertinent patient health information (PHI) and/or personal contact information it deems necessary with its contracted third party affiliates and/or electronic communications platforms to aid in the administration of health benefits and /or electronic communications.

_____

Patient Signature

Espanol

Wellness Form

First Name | Last Name | Phone | Email

Do you have a cough?

Yes No

Do you have a fever now or have you in the past 14-21 days?

Yes No

Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?

Yes No

Are you experiencing shortness of breath or difficulty breathing?

Yes No

Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

Yes No

Have you experienced recent loss of taste or smell?

Yes No

Are you over the age of 60?

Yes No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

Yes No

Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

Yes No

Submit

Signature

Powered by weave

Date