Dr. J.P. Walters D.D.S. PLLC

*** Please complete and sign all areas requesting a signature.***

Patient Name:

First:_____ Last: _____Date of Birth:_____ SS#:_____

Address: _____City:_____State:_____Zip:_____

Home Phone:_____Work:_____Cell:_____Email_____

Responsible Party if different from above:

Name First: _____ Last:_____ Date of Birth:_____

Relationship to patient:_____SS#:_____Address:_____

City: _____St:_____Zip:_____Phone:_____Employer:_____

Phone:_____Spouse:_____Employer:_____Phone:_____

Emergency Numbers:

Name: _____Phone:_____

Dental Insurance:

I will review the treatment plan and fees and I hereby authorize payment of the dental benefits otherwise payable to me to go directly to Dr. J.P. Walters Signature on file:_____Date:_____

Insurance Company:_____Plan:_____Group:_____

Phone:_____Employer:_____Phone:_____
Provider's Name: _ _____SS#:_____Date of Birth_____

1. Insurance Company: _____Plan: _____Group:_____
   Phone:_____Employer:_____Phone:_____
   Provider's Name: _____SS#:_____Date of Birth: _____
   Upon written request my permission is granted to Dr. Walters's office to release my/our complete records to another dental or medical clinic/practice. I release Dr. J.P. Walters and staff from any loss related to disclosure of confidential or privileged information.
   ****Signature:_____Date:_____****

Payment is due at time of appointment, unless prior arrangements have been made.

Upon signing, you understand that any unpaid balance is your responsibility. Our insurance and payment policy is attached with full explanation. Payments (if accepted) are to be made monthly on or before the 15th of each month. Any unpaid balance may be subjected to legal fees, collection fees, and/or reported to credit bureaus.

Signature: _____date:_____

Dental History

Name:_____

Before dental treatment do you need to pre-Medicate? _____What do you take?_____

Are you having any discomfort at this time? _____

Have you ever had any serious trouble associated with Previous dental treatment? _____

How nervous does dental treatment make you?

_____

Date of last dental visit:_____

How often do you brush? _____per day_____

How often do you floss?_____per day_____

Do you or have you ever had the following:

Bleeding/sore gums_____

Unpleasant taste/bad breath _____

Burning tongue or lips_____

Frequent Blisters mouth/lips _____

swelling/lumps in mouth_____

Ortho treatment (braces)_____

Biting cheeks/lips_____

Clicking or popping jaw_____

Difficulty opening or closing_____

Change or shift in bite_____

Loose teeth_____

sensitive to hot ,cold or sweets_____

Food impactions _____

Clenching or grinding _____if yes when____

Do you use: (please circle)

Manual tooth brush/Electric tooth brush

Perio-aid /Proxabrush/ fluoride

Personal Physician:_____Phone:_____

Are you taking any medications? If yes, please list :_____

_____

Please circle those you have had:

Heart failure
Heart attack
Angina or chest pain
High blood pressure
Congenital heart defect
Mitral valve prolapse
Heart Murmur
Rheumatic fever
Artificial heart valve
Breathing difficulties
Irregular beat/arrhythmia
Pacemaker/defibrillator
Diabetes
Aids
Herpes or other STD
Thyroid disease
Sinus problems
Bronchitis
Emphysema
Tuberculosis
Allergy to latex (rubber gloves)
Arthritis or rheumatism
Fever blisters
Canker sores
Fainting spells

Hemophilia
Stomach ulcers
reflux GERD
hepatitis or jaundice
Colitis
persistent diarrhea
cirrhosis
Chemotherapy
Cancer
enlarged lymph nodes or glands
Substance abuse
any joint replacements: _____
Are there any health matters listed we need to be aware of ?
If yes please list them below:
_____
_____
Vision problems
mouth ulcers
Blood Transfusion
Anemia
Leukemia
Bleed longer than normal
Sickle cell anemia

Tobacco use: _____

Alcohol use: _____

Recreational drug use: _____

Allergies: (Please circle)

Penicillin or other antibiotics
codeine, Demerol, or other narcotics
sulfa, reaction to metals
Aspirin, Acetaminophen or Ibuprofen
Latex gloves, Tetracycline,Erythromycin
Other: _____

If you are a woman: are you pregnant?
_____when is your baby due?_____

Are you taking birth control or hormone therapy? _____

The Information I provided is Correct to the best of my *Knowledge. I am aware that it is* my responsibility to personally inform Dr. Walters of any Changes:

Signature:_____

Date: _____

*** Thank you for being our patient! ***

Insurance And Payment Policy

Insurance Policy: All aspects of insurance are your full responsibility. Please keep us updated with current insurance information. As a courtesy to patients we are happy to process your claim. Co-payments and deductibles are expected at time of service. Insurance payments are made directly to Dr. J.P. Walters. Sadly, there are times when an insurance company will not pay: In this case, you are responsible for any unpaid claims and any balance on your account.

Payment Policy: Payment is expected at the time of service, unless other arrangements are made. We Gladly take: Visa/Master Card, American Express, Check, money order and cash. We also offer financing With a third party credit company, CareCredit. Applications are available upon request.

Note: Upon Signing you agree you are responsible for your account as well as any family member under The age of 18.Insurance payments are to be sent directly to Dr. Walters D.D.S. You are responsible for any cost developing in collecting a balance over 60 days such as: legal action, court cost, collection fees, etc.

Cancellation Policy

Appointments are reserved in advance exclusively for you. We ask our patients to give us **at least 24** hour notice if you need to cancel or reschedule an appointment. We will give you the same respect and will not cancel your appointment due to a schedule change without a 24 hour notice. We have an office policy that after 3 missed appointments we are unable to reschedule an appointment for you. Emergencies are an unforeseen problem that may arise causing a schedule change. We understand and ask that our patients give us a courtesy call and let us know that they will be unable to make their appointment. Please feel free to ask if you have any questions about our policy.

Signature: _____Date:_____

Print Signature:_____ Taken by:_____

Staff Initials

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosers of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes:

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosure that are prohibited or materially limited by law. A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.

My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:

- The right complain to this practice and to secondary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of sucha complaint.
- The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
- The right to receive confidential communications of protected health information.
- The right to inspect and copy protected health information.
- The right to amend protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy notice of privacy practices from this practice upon request.

This Practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provision effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____Date: _____

Relationship to patient (If signed by personal representative of patient):_____