DARCY A. WAKEFIELD, DDS

951 Stuebenville Avenue
Cambride, OH 43725

Patient Registration

Patient's Name | **Birth date** | **Age** | **Sex: M F**

Home Address	**City**	**State**	**Zip**

Home Phone # **Work Phone #** **YOUR cell phone #**	***Please Circle One:***	
Your Employer	Single, Married, Separated, Widow	**Your Soc Sec. #** **(is not necessary if paying at the time of service)**
Occupation		

Are you a full time student? ☐Yes ☐ No *If patient is minor we need:* *Mother's Name & Birth date* *Father's Name & Birth date*

Person paying this bill **YOUR Driver's License Number**

Name of spouse (or parentif minor) **YOUR E-mail address**

Spouse's (or parent's) employer **Spouse's Soc. Sec. #** **Work phone #**

EMERGENCY INFORMATION

Name, Address, & Telephone of A relative not living with you:

How did you hear about our office?

Reason for your visit today ?

DENTAL INSURANCE INFORMATION (Primary Carrier)	**If you have a dual insurance coverage, complete this for the second coverage (this office bills primary ins only)**
Insured's name DOB SS#	Insured's name DOB SS#
Insured's employer	Insured's employer
Insurance Co	Insurance Co
Insurance Co Address	Insurance Co Address
Phone #	Phone #
Group # Policy #	Group # Local #

Patient Signature (or Parent of Child) **Date**

DENTAL HISTORY

Please check the following :	YES	NO
-Sensitivity (hot, cold, sweet)		
Where? UR LR UL LL		
-Headaches, ear aches, neck or jaw joint pain		
-Mouth ulcers or cold sores		
-Teeth or fillings breaking		
-Grinding or clenching teeth		
-Bleeding, swollen or irritated gums		
-Loose, tipped or shifting teeth		
-Bad breath		
Do you have or have you had any of the following?		
-Dentures		
-Partial dentures		
-Braces		
-Gum treatments		

Please share the following dates:

-Your last cleaning ___/ ___

-Your last oral cancer screening ___/ ___

-Your last complete X-Rays ___/ ___

Name of Previous Dentist ________________________

City _________________________ **State** ________

Phone Number ________________________________

What is the most important thing to you about your future smile and dental health? ____________________

	YES	NO
If you could whiten your teeth for a cost anyone could afford, would you do it?		
Do you smoke or use chewing tobacco?		
How much? For how long?		
If I could change my smile, I would:		
-Make my teeth whiter		
-Make my teeth straighter		
-Close spaces		
-Replace metal fillings with tooth colored restorations		
-Repair chipped teeth		
-Replace missing teeth		
-Replace old crowns that don't match		
-Have a smile makeover		

On a scale of 1 – 10, with 10 being the highest rating:

-How important is your dental health to you?

1 2 3 4 5 6 7 8 9 10

-Where would you rate your current dental health?

1 2 3 4 5 6 7 8 9 10

Why did you leave your previous dentist?

____

____

What is the most important thing to you about your dental visit today? ____________________________

MEDICAL HISTORY

Please check any of the following that apply to you:

Y N	Y N	Y N	Y N
Allergies (Seasonal)	Emphysema	Osteoporosis	Ulcers
Anemia	Fainting	Jaundice	Other:
Arthritis	Glaucoma	Jaw Joint Pain	
Artificial Joints	Head Injuries	Pacemaker	**For WOMEN Only**
Artificial Heart Valve	Heart Disease	Pre-Medication	Birth Control Pills
Asthma	Heart Conditions	Radiation (head/neck)	Breast-feeding
Back Problems	Heart Murmur	Respiratory Problems	Pregnant
Cancer	other Heart conditions	Seizures	1-3 mos, 3-6 mos, 6-9mos
Chemotherapy	Hepatitis A B C	Stomach Problems	
Circulatory Problems	High Blood Pressure	Stroke	
Diabetes	Low Blood Pressure	Swelling – Feet/Ankles	
Dizziness	Kidney Disease	Thyroid Disease	
Excessive Bleeding	Liver Disease	Tuberculosis	

Do you have any of the following drug allergies?

Aspirin	Penicillin
Codeine	Sulfa
Erythromycin	Tetracycline
Ibuprofen	Tylenol
Latex	Other

Are you under a physician's care? What for?

____

Are you taking any medications? What?

____

____

____

Is there any other medical or dental information we should know about? ___________________________________

DARCY A. WAKEFIELD,DDS,LLC OFFICE POLICIES:

Treatment Consent: You will be asked to sign consent to receive specific dental services. This consent must be signed prior to receiving any treatment.

Patients with Dental Insurance: If we have received all of your insurance information on the day of the appointment, we will be happy to file your claim for you at no charge. We will collect from you an estimated amount insurance is not expected to pay at each appointment. We file all insurance electronically so your insurance company will receive each claim within days of treatment. You are responsible for any balance on your account after insurance payment has been received. No additional appointments will be made for you until balances are paid off. A finance charge of 3% per month will be applied to any unpaid balance over 30 days. We will be glad to send a refund to you once insurance has paid to us if one is due to you.

If you can not provide us with all of your insurance information on the due date of your appointment, you will be required to pay in full for dental service rendered. We will provide you with a receipt of your services so that you can file your claim with your insurance company to be reimbursed for payments made to us. Please provide us with documented reimbursement information if any refund may be due to you.

PLEASE UNDERSTAND that we file dental insurance as a courtesy to our patients. We do not have to contract with your insurance company, only you do. We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. We can only assist you in estimating your portion of the cost of treatment. We at no time guarantee what your insurance will or will not be responsible for any errors in filing your insurance. Once again, we file as a courtesy to you.

Dental Insurance Co-pays: At each appointment,you will be expected to pay an estimated amount that your insurance will not cover of your dental services you receive that day. These estimates are 20% for all fillings,extractions,and root canal; 25% at the 1st appointment for crowns, bridges, partial dentures, and complete dentures. This 25% is non-refundable in the circumstance that treatment is not completed by you. We will need payment in full by the final appointment for all crowns, bridges, partial dentures and complete dentures either by you or your insurance company. Once your insurance has paid,you will be billed or refunded accordingly.

Crowns, Bridges,Partial Dentures, and Complete Dentures: If you do not have insurance for these procedures, you will be required to pay 50% of the total cost at the first appointment. 25% of the total cost is nonrefundable in the circumstance that treatment is not completed by you. Please ask us about our financing options available.

Appointment Cancellations: An automated system will call you to confirm your appointment 48 hours prior to the appointment. Kindly give us at least 24 hours notice if needing to cancel your appointment. Appointments canceled or broken with less than 24 hours notice will require a non-refundable payment to reschedule.

Payments: Payment of a professional services is due at the time dental treatment is provided. Every effort will be made to provide a treatment plan which fits your timetable and budget, and gives you the best possible care. We accept cash, personal checks, debit cards, and most major credit cards. If you are in need of financing, please let us know. There will be a $30.00 fee for any returned check.

Please contact our front office staff if you would like an additional copy of these policies.
I______________________,have read and understand the office policies of Darcy A. Wake field, DDS.

_____________________________   __________________
Signature   Date

Darcy A. Wakefield DDS, LLC Payment Policy – Effective March 2009

Patient Name:____Date:
Date of Birth:____________________________ Phone: (______)_________- _________
Responsible Party's Name: ____

We offer several different payment options. Payment is expected at time of service for all patients. Please choose one of the fallowing payment options by placing a check in front of the number:

☐ 1. Full Pay Day of Service Discount:

We offer a 5% accounting courtesy for all treatment that is paid in full with Cash, or Credit Card (Visa,Master Card, or Discover). If you have dental insurance, we will still file it with the insurance company and reimburse you their payment.

☐ 2. Insurance Deductible/ Co-pay with credit card on file:

Insurance Deductible/ Co-pay is collected in addition to placing a credit card with a signature and signed agreement on file. A courtesy to you, we will file your insurance claim. If insurance denies payment or there is a remaining balance, it will be billed to the Credit Card on file. A 3% per month finance charge will be applied to the balances over 30 days.

☐ 3. Third Party Financing Company (Care Credit):

This allows you to begin treatment with no down payment, and have monthly payments extended over an extended period, with interest charged by the third-party financing company.

All Emergency Exam Patients: Must have a credit card with signature and agreement on file. Payment may be collected prior to the appointment.

Responsible Party's Credit Card Information:

Card Number:_____________________________________3 Digit Pin #:
Name as it appears on Credit Card: ____
Expiration Date: __________________________
I,____(responsible party), authorize Darcy A. Wakefield, DDS, LLC to bill to the above Credit Card for any balance on my account under the above conditions.

Consent:
I have read, understood and agree to the above arrangement for dental care.

Patient's Signature X ____

Responsible Party's Signature X

DARCY A. WAKEFIELD, DDS, LLC
Family & Cosmetic Dentistry
951 Steubenville Ave.
Cambridge, Ohio 43725
740-435-3100

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I received a copy of Darcy A. Wakefield, DDS, LLC's Notice of Privacy Practices.

Patient Name: ____

Signature:_____________________________________ Date: ___________________