

FORT WAYNE SMILES, PC

State-of-the-Art Family, Cosmetic, Implant & Laser Dentistry

- Solutions for the Quality Conscious

Welcome!

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

- Dr. David P. Reichwage and Team

ABOUT YOU

SPOUSE and EMERGENCY INFORMATION

Name _____

I prefer to be called _____ M F

Birthdate ___/___/___ SS# _____

Address _____ Apt. _____
_____ Zip _____

Single Married Divorced Widowed Separated

Hm # (____) _____ Cell/Pager # (____) _____

Wk # (____) _____ Ext # _____

Email _____ DL # _____ State _____

Please star above at least 2 #'s where to best reach you.
What is best time to reach you between 7:30-5:00? _____

Employer _____

Address _____
_____ Zip _____

Occupation _____ How long? _____

Whom may we thank for referring you? _____

_____ My other family members who should
have a dental appointment are _____

Prior/Present Dentist _____

Ph # (____) _____ City _____ State _____

Approximate date of last visit ___/___/___

Legal guardian _____

Address _____
_____ State _____ Zip _____

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

Ext # _____ SS# _____

Employer _____

Address _____

His/Her Name _____

Employer _____

Wk # (____) _____ Ext.# _____

SS # _____ Birthdate ___/___/___

Emergency Contact: _____

Relationship _____ Hm # _____

Wk # _____ Ext _____ Cell # _____

YOUR DENTAL PLAN

PRIMARY DENTAL BENEFIT

Please answer all questions in order to minimize problems with your dental benefit plan.

Insurance Company _____

Insurance Co. Address _____

_____ Zip _____

Ph # (____) _____ Toll-free # (____) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relationship _____ Birthdate ___/___/___

SS# _____ Wk # (____) _____ Ext _____

Insured's Employer _____

Address _____

_____ Zip _____

SECONDARY DENTAL BENEFIT

Insurance Company _____

Insurance Co. Address _____

_____ Zip _____

Ph # (____) _____ Toll-free # (____) _____

Group # (Plan, Local or Policy #) _____

Insured's Name _____

Relation _____ Insured's Birthdate ___/___/___

SSN# _____ Wk # (____) _____ Ext _____

Insured's Employer _____

Address _____

_____ Zip _____

PLEASE COMPLETE REVERSE SIDE

MEDICAL HISTORY

How can we best help you TODAY? _____

How would you describe the condition of your teeth and gums? Good Fair Poor

How would you describe the appearance of your smile? Attractive OK Poor

Are you currently in pain or discomfort with your teeth or gums? Yes No If yes, please explain.

How often do you brush? _____ Floss? _____

Do your gums bleed when you brush?

Yes No Floss? Yes No

Have you ever experienced pain in your jaw joints?

Yes No If yes, please explain. _____

Have you ever been treated for TMJ? Yes No

If yes, please explain. _____

Do you grind or clench your teeth? Yes No

I authorize this practice to perform necessary dental services that I need during diagnosis and treatment with my consent, and to submit my data to my dental plan, medical, dental or collection organizations as needed for my treatment or payment I authorize use of photos for lecturing, publishing or education.

I, or my legal guardian, am fully responsible for my account and for reasonable collection/legal fees incurred in obtaining payment. Payment, or my dental plan's required copay, is due in full at the time of service unless I have made specific and complete prior arrangements. I will pay my account in full within 30 days from date of service, including any balance left unpaid at that time by my dental plan.

This information is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this practice of any changes in my medical status or in my dental plan prior to treatment.

FWS, PC can discuss my health with spouse ___ children ___

Others _____

signature _____

printed signature _____

date ____ / ____ / ____

Your physical health is: Good Fair Poor

Are you under a physician's care? Yes No If yes, please explain. _____

Are you taking prescription/over-counter drugs? Please list _____

Women: Do you use birth control pills? Yes No

Are you Pregnant? Yes No Week # _____

Are you nursing? Yes No

Have you ever had or been treated for any of the following?

Y N Anemia
 Y N Anorexia/Bulemia
 Y N Arthritis
 Y N Artificial Bones/Joints
 Y N Asthma
 Y N Bacterial Endocarditis
 Y N Blood Disease/
 Bleeding
 Y N Blood Pressure
 Y N Cancer/Chemotherapy
 Y N Chemical Dependency
 Y N Chest Pain
 Y N Chronic Diarrhea
 Y N Codeine Allergy
 Y N Diabetes
 Y N Dizziness
 Y N Ear Infections
 Y N Enzyme Deficiency
 Y N Epilepsy
 Y N Erythromycin Allergy
 Y N Fainting
 Y N Glaucoma
 Y N Growths
 Y N Hay Fever
 Y N Head Injuries
 Y N Headaches
 Y N Heart Disease
 Y N Heart Murmur
 Y N Hepatitis
 Y N HIV/Aids
 Y N Immune Suppression
 Y N Jaundice
 Y N Kidney Disease
 Y N Latex Allergy

Y N Liver Disease
 Y N Lung Ailments
 Y N Mental Disorders
 Y N Mitral Valve Prolapse
 Y N Nervous Disorders
 Y N Organ Transplants
 Y N Other _____

Y N Pacemaker
 Y N Penicillen Allergy
 Y N Persistent cough
 Y N Premedication
 Y N Radiation Treatment
 Y N Respiratory Problems
 Y N Rheumatic Fever
 Y N Rheumatism
 Y N Sedative(s)
 Y N Seizures
 Y N Shortness of Breath
 Y N Sinus Problems
 Y N Stomach Problems
 Y N Stroke-Heart Attack
 Y N Sulfa Allergy
 Y N Tetracycline Allergy
 Y N Thyroid Condition
 Y N Tuberculosis
 Y N Tumors
 Y N Ulcers
 Y N Venereal Disease
 Y N Allergic to Dental
 Anaesthetic
 Y N Allergic to Aspirin

Please list any other drug

allergies _____

List any serious medical condition(s) you have ever had:

Do you require an antibiotic before dentistry?

YES NO

FORT WAYNE SMILES, PC

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed. Please review it carefully.

Fort Wayne Smiles, PC, respects your privacy. The health information we create and obtain in providing care and services to you is protected by law. We understand that your personal health information is sensitive. You must note in your health history, and periodically update with us, those individuals who have the right to discuss your information with us, unless the law authorizes or requires us to do so. Your protected health information includes your symptoms, diagnosis, treatment and other information pertaining to your visit.

Your Health Information Rights

The records we create are property of Fort Wayne Smiles, PC. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this Notice
- Request by letter that you be allowed to see and get a copy of your protected health information.

Our Responsibilities

We are required to:

- Keep your health information private except to those you
- identify,
- Give you this notice
- Follow the terms of this notice.

We have the right to change our practices regarding the health information we maintain. If we make changes, we will update this Notice.

Law determines how your protected health information can be used and disclosed without your consent::

- For problems with food, supplements and products to the FDA,
- For workers' compensation claim data should a claim involving you be made,
- For public health and safety purposes as allowed or required by law:
 1. to public health and legal authorities to protect public health and safety,
 2. to prevent or control disease, injury or disability,
 3. to prevent or reduce a serious threat to the public health or the safety of a person,
- For law enforcement should we receive a subpoena, court order or other legal process, or if you are the victim of a crime,
- For health and safety oversight activities, to agencies such as the Department of Health,
- For work-related conditions that could affect employee or public health, for example, should an employer ask us to assess health risks on a job site.

Other uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization. I understand and agree to the terms of this Notice.

Name_____ Printed Signature_____ Date_____