Patient Registration

Patient Information

First Name
-

Last Name
-

Middle Name
-

Date of Birth
-

Residential Address
-

City
-

State
-

Zip
-

Gender
-

Marital Status
-

Social Security Number
-

Contact Information of the Patient

Email
-

Home Phone Number
-

Cell Phone Number
-

Work Phone Number
-

Work Extension Number
-

Responsible Party's Information

Full name
-

Street address
-

City
-

State
-

Zip
-

Home Phone Number
-

Cell Phone Number
-

Work Phone Number
-

Work Extension Number
-

Social Security Number
-

Driving License Number
-

Emergency Contact Information

Full name
-

Phone number
-

Primary Dental Insurance Details

Date of Insured
-

Dental Group Number
-

Dental Member ID
-

Name Of Insured
-

Relation To Patient
-

Insured SSN
-

Employer Name
-

Insured Person's Address
-

Insurance Company
-

Insurance Company Address
-

Insurance Company City
-

Insurance Company State
-

Insurance Company ZIP Code

-

Electronic signature (ESign)

Date :

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease)_	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)** ○ ○ ○

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____/____/____ Date of most recent x-rays ___/____/____

Date of most recent treatment (other than a cleaning) ____/____/____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

	YES	NO
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2. Have you had an unfavorable dental experience?	☐	☐
3. Have you ever had complications from past dental treatment?	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE	**YES**	**NO**
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8. Have you ever had or been told you have gum disease, gum or bone loss between your teeth, or had scaling and root planing?	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10. Is there anyone with a history of periodontal disease in your family?	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE	**YES**	**NO**
14. Have you had any cavities within the past 3 years?	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18. Do you have grooves or notches on your teeth near the gum line?	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20. Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT	**YES**	**NO**
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26. Are your teeth developing spaces or becoming more loose?	☐	☐
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30. Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32. Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS	**YES**	**NO**
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34. Have you ever bleached (whitened) your teeth?	☐	☐
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36. Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Witkowski Dental

DR. LEON J. WITKOWSKI III, D.D.S.

Leon J. Witkowski III, D.D.S.
Leslie Clevenger, D.D.S.
Emili Hester, D.D.S.
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Receipt of Notice of Private Practices and current Office Policy Written Acknowledgement Form

I, _____, have received and/or read a copy of

Notice of Private Practices and Office Policy.

_____

Signature of patient or guardian

Date: _____

A HIPPA booklet is available upon request

Witkowski Dental

Financial Policies

Our dental office files with all PPO insurance companies.
However, we are NOT in network with any company.
You will receive out of network benefits when submitting claims.
Initials: _____

Our business office will provide a complimentary **pre-treatment authorization** upon your request. However, even a preauthorization does not guarantee payment from your insurance company. For your convenience, we will also file your claim for you. We require photo identification and current insurance information to promptly file your claim. When insurance is involved, we are obligated to collect co-payments, co-insurance as well as deductibles as stated by your insurance company. **Even though we do all we can to work with you and your insurance company, ultimately, you are responsible for payment of any dental procedures or services.**
Initial: ____

Patients without insurance:

There are **multiple options** available for you even without dental insurance. The following options are available to you in order to keep your account current.

1. We accept personal checks, cash, Mastercard, Visa, and Discover credit cards. We also offer Care credit. Care credit is a reasonable short-term financing option available to patients. For more information, please go to carecredit.com or ask about the option in our business office.
2. Payments in full will be expected at the time of treatment. When paying in full we offer a 5% discount applied at the time of treatment.
3. For major dental treatment, we require ½ of the fee to be paid at the time of service and financial arrangement(s) on balances to be discussed with the business office.

Initials: __

Patients with insurance:

The doctor does not have a contract with any insurance company. However, that does not mean your insurance provider will not pay on treatment. Once insurance provides payment the remaining balance will become your obligation. It is the responsibility of the patient to make sure that he/she pays on time. Patients with insurance are still able to take advantage of Care credit, a 0% short term financing option, to pay their remaining balance. Please visit carecredit.com or ask our business office for more details.

All statements and financial obligations are the responsibility of the patient. If your insurance has changed, it is your responsibility to notify our office with the new information. We make every effort to file and track your insurance. If, for some reason, insurance does not pay within a reasonable amount of time (60 days), the balance is required to be paid by the patient. We understand extenuating or uncontrollable financial circumstances. During tough economic times we are here to discuss options if you need to arrange a financial solution. We pride ourselves on the personal relationships we have with our patients and we ask you respect the agreed upon financial arrangement. Lack of communication in regards to your account, will require us to refer to a third-party collection agency.

Witkowski Dental

Insurance checks sent to the subscriber

As an out of network provider, there are insurance companies that send insurance payment checks to the subscriber. Here is what your choices are should your insurance send payment to the subscriber on file:

The checks will be delivered via USPS and you have 2 choices on what to do with the payments.

- Deposit the check and provide payment in full to the rendering provider with your preferred form of payment.
- Endorse the check and provide it to us, the providing office, and pay the remaining balance with your preferred form of payment for the remaining balance.

We kindly request that you forward the full amount of the insurance payment(s) to our office as soon as possible. A reminder, again, these checks are payments for services rendered. We are happy to extend payment plans for your patient portion, but these checks are required upon being issued and your account subject to being sent to a collection agency. **We do not payment plan insurance checks.**

Signature: _____Date: _____