RICHARD WETHERILL III, D.D.S.

FAMILY DENTISTRY

1209 FLORAL PARKWAY, SUITE A
WILMINGTON, NORTH CAROLINA 28403

910-792-1085

Patient's Name _____
Last First Middle

Date of Birth _____ Age _____ SSN_____ [ ] minor [ ] single [ ] married [ ] widowed

Name of Spouse (if applicable)_____

Name of Parent (if applicable) _____

Home Address_____
Street City State Zip

Home Phone (_____) _____ Cell Phone (_____) _____

Name of Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

DENTAL INSURANCE

Primary Insurance

Insured Name_____ SS#_____ Date of Birth_____

Insured's Employer _____Insurance Plan Name _____ Group #_____

Customer Service Telephone _____ Patient's relationship to insured _____

Secondary Insurance

Insured Name_____ SS#_____ Date of Birth_____

Insured's Employer_____Insurance Plan Name _____ Group #_____

Customer Service Telephone _____ Patient's relationship to insured _____

Financial Information for our Patients

- As a courtesy to our patients, our office will assist you in obtaining the maximum benefit from your insurance.
- Payment Policy: Our office is a fee for service office, meaning we politely ask you for payment **in full** at the time services are rendered. For your convenience, we accept most Dental Benefits, Cash, Check, Visa or Mastercard.
- We charge $30 returned check fee and a $30 collection fee for accounts sent to our outside collection agency.
- Our courtesy service to you includes electronically filing your insurance within 24 hours of your appointment so benefits may be paid directly to our office by following the American Dental Association guidelines for coding and filing insurance claims.
- Our expectation of you as the owner of the policy is to make payment in full of fees or co-payments not covered by your insurance plan at the time services are rendered. We also ask that you understand that the policy belongs to you and we have no leverage to obtain payment from your insurance. With that, we ask you to take responsibility for payment of your visit should your insurance company not pay within 45 days. A service charge of 1.5% will be added to all accounts 30 days past due (EXCLUDING PENDING INSURANCE for 45 days). In order to avoid this situation, we ask that you keep our office informed of any changes in your insurance coverage or employment.
- Every dental insurance policy has a maximum benefit, which we are able to track for services rendered in our office. If you have received care by another office, we cannot be responsible for calculating your remaining benefits accurately. You may call your insurance company to receive an updated amount after services have been paid to all offices involved.
- On the date of your office visit, you are responsible for your deductible and the portion we estimate the insurance will not cover. However, if our estimates are inaccurate, there will be a need to send you a statement for the balance due.

I hereby authorize benefits to be paid directly to Dr. Richard Wetherill III, D.D.S. I understand I am responsible for any unpaid balances or dental services not paid by my dental benefit plan. I have read and agree to this Financial Policy.

_____

Signature of Patient or Responsible Party **Today's Date**

Medical History

Please check any of the following, which you have had or presently have:

Head and Neck
- □ Sinus problems or allergies
- □ Pain in jaw joint or TMJ
- □ Hearing impaired
- □ Headaches
- □ Radiation treatments
- □ Cancer—year _____
- □ Fever blisters/canker sores
- □ Other _____

Lungs
- □ Asthma
- □ Emphysema
- □ Tuberculosis (TB)
- □ Difficulty breathing
- □ Respiratory problems
- □ Other _____

Stomach
- □ Ulcers
- □ Colitis
- □ Surgery
- □ Other _____

Liver
- □ Hepatitis A/B/C
- □ Liver disease/jaundice
- □ Other_____

Heart
- □ High blood pressure
- □ Low blood pressure
- □ Heart disease or heart attack
- □ Congestive heart failure
- □ Pacemaker - year _____
- □ Stroke
- □ Heart surgery—year _____
- □ Artificial heart valve
- □ History of infective endocarditis
- □ Serious congenital heart condition
- □ Heart murmur
- □ Other

Blood
- □ Abnormal bleeding
- □ Anemia
- □ Hemophilia
- □ Blood clots
- □ HIV or AIDS
- □ Other _____

Kidney
- □ Dialysis
- □ Transplant—year _____
- □ Failure/Disease
- □ Other _____

Joints
- □ Artificial hip—yr. replaced _____
- □ Artificial knee—yr. replaced _____
- □ Arthritis
- □ Surgery
- □ Other _____

Systemic Disease
- □ Diabetes
- □ Cancer—year _____
- □ Chemotherapy
- □ Radiation treatment
- □ Thyroid disease
- □ Epilepsy or seizures
- □ Syphilis/gonorrhea/herpes
- □ Drug or alcohol problems
- □ Psychiatric problems
- □ Surgery _____
- □ Other _____

Females
- □ Pregnant—due date _____
- □ Nursing
- □ Birth control pills
- □ Hormone therapy
- □ Other _____

Dental History

- □ Periodontal disease
- □ Gingival/gum grafting
- □ Oral surgery/implants
- □ Orthodontic work
- □ Clenching/grinding

Last dental cleaning_____

Last dental radiographs _____

Medications

List medications you are currently taking (including nonprescription drugs).

_____

_____

_____

Have you ever taken Fosamax, Actonel, Zometa, or Arenia?_____

List medications to which you are allergic (including anesthetics, latex, aspirin, penicillin, etc.)

_____

_____

Have you ever been told to take antibiotic premedication prior to dental treatment? _____

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

Please list your physician's name and phone number:_____

I have read and answered all questions to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

Signature _____ Date _____