Christian R. Willard, D.D.S., P.C
523 State Highway 248, Suite A
Branson, MO 65616
417-336-2404 www.248dental.com willarddental@live.com

Patient Name: _____ Spouse/Guardian _____
Last First Middle Last First Middle

How do you wish to be addressed _____ Spouse/Guardian Address: _____

Address: _____ City, State, Zip: _____

City, State, Zip: _____ Spouse/Guardian Cell Phone: _____

Home Phone: _____ Spouse/Guardian Work Phone: _____

Work Phone: _____ Spouse/Guardian Birthday: _____

Cell Phone: _____ Spouse/Guardian Social Security: _____

Patient Email: _____ Spouse/Guardian Email: _____

Patient Birthday: _____ Spouse/Guardian Employer: _____

Patient Social Security Number: _____ Spouse/Guardian Occupation: _____

Patient Marital Status: S M D W

Patient Employer _____ Employer's Phone: _____

May we contact you and leave messages at all above phone numbers to confirm appointments? (circle one): Yes or No**

****IF NOT, please specify appropriate phone numbers:** _____

Person to notify in case of emergency _____ Relationship _____ Phone# _____

Physician's Name: _____ Phone Number: _____

Patient's Preferred Pharmacy: _____ Who Referred you or your family _____

Person(s), Relationship, & Phone Numbers you authorize discussion of personal treatment, account information, & billing:

_____

DENTAL INSURANCE INFORMATION—MUST HAVE A COPY OF YOUR DENTAL INSURANCE CARD ON FILE

Subscriber's Name: _____ Name of Insurance Company: _____

Subscriber's Social Security # (required to file) _____ Insurance Company Phone Number: _____

Subscriber's Relationship to Patient: _____ Subscriber ID# _____

Subscriber's Birthday (required to file): _____ Subscriber Group # _____

AUTHORIZATION: I have completed this form fully and completely and certify that I am the patient or duly authorized general agent of the patient to furnish the required information requested.

I understand that even though I might have a form of insurance coverage, I am fully responsible for all payments at the time of service, including my deductible and co-payments which the insurance does not cover.

I understand that my insurance carrier may pay less than the actual bill for services and I am financially responsible for the payment in full.

I understand that where appropriate, credit bureau reports may be obtained. We accept MasterCard, Visa, American Express, Discover Card, cash, and personal checks. No postdated checks.

Signature of Patient, Parent, Guardian, or Responsible Party: _____ **Date:** _____

MEDICAL HISTORY

Date: _____

Patient Name_____ Date of Birth_____

Check (X) If you have or have had problems with any of the following:

AIDS/HIV Positive	◻ Yes	◻ No	Diabetes	◻ Yes	◻ No	Neurological Problems	◻ Yes	◻ No
Allergies	◻ Yes	◻ No	Emphysema	◻ Yes	◻ No	Pacemaker	◻ Yes	◻ No
Anemia	◻ Yes	◻ No	Endocarditis	◻ Yes	◻ No	Psychiatric Care	◻ Yes	◻ No
Angina	◻ Yes	◻ No	Epilepsy	◻ Yes	◻ No	Radiation Treatment	◻ Yes	◻ No
Anxiety	◻ Yes	◻ No	Fainting or dizziness	◻ Yes	◻ No	Respiratory Disease	◻ Yes	◻ No
Arthritis, Rheumatism	◻ Yes	◻ No	Fibromyalgia	◻ Yes	◻ No	Rheumatic Fever	◻ Yes	◻ No
Artificial Heart Valves	◻ Yes	◻ No	Glaucoma	◻ Yes	◻ No	Scarlet Fever	◻ Yes	◻ No
Artificial Joints	◻ Yes	◻ No .	Headaches	◻ Yes	◻ No	Shortness of Breath	◻ Yes	◻ No
Asthma or Hay Fever	◻ Yes	◻ No	Heart Attack	◻ Yes	◻ No	Seizures	◻ Yes	◻ No
Back Problems	◻ Yes	◻ No	Heart Murmur	◻ Yes	◻ No	Sinus Trouble	◻ Yes	◻ No
Bleeding abnormally, with extractions or surgery	◻ Yes	◻ No	Heart Disease	◻ Yes	◻ No	Skin Rash	◻ Yes	◻ No
			Hemophilia	◻ Yes	◻ No	Special Diet	◻ Yes	◻ No
Blood Disease	◻ Yes	◻ No	Hepatitis Type _____	◻ Yes	◻ No	Stroke	◻ Yes	◻ No
Blood-Transfusion	◻ Yes	◻ No	Herpes	◻ Yes	◻ No	Swollen Feet or Ankles	◻ Yes	◻ No
Cancer Therapy	◻Yes	◻ No	High Blood Pressure	◻Yes	◻ No	Swollen Neck Glands	◻ Yes	◻ No
Chemical Dependency	◻ Yes	◻ No	Jaundice	◻ Yes	◻ No	Thyroid Problems	◻ Yes	◻ No
Chemotherapy	◻ Yes	◻ No	Jaw Pain	◻ Yes	◻ No	Tonsillitis	◻ Yes	◻ No
Circulatory Problems	◻ Yes	◻ No	Kidney Disease	◻ Yes	◻ No	Tuberculosis	◻ Yes	◻ No
Claustrophobia	◻ Yes	◻ No	Leukemia	◻ Yes	◻ No	Tumor or Growth on Head or Neck	◻ Yes	◻ No
Congenital Heart Lesions	◻ Yes	◻ No	Liver Disease	◻ Yes	◻ No	Ulcer	◻ Yes	◻ No
Contact Lenses	◻Yes	◻ No	Low Blood Pressure	◻Yes	◻ No	Venereal Disease	◻ Yes	◻ No
COPD	◻ Yes	◻ No	Measles or mumps	◻ Yes	◻ No	Weight Loss, unexplained	◻ Yes	◻ No
Cortisone Treatments	◻ Yes	◻ No	Mitral Valve Prolapse	◻ Yes	◻ No			
Cough, persistent or bloody	◻ Yes	◻ No	Nasal Obstruction	◻ Yes	◻ No			

Medications routinely used in dental treatment may interact with both prescription and a number of illegal street drugs. Check (X) the medications you are presently taking, medications you have taken in the past, or medications you have had an adverse reaction to:

	Presently Taking	Taken In the Past	History of Reaction		Presently Taking	Taken In the Past	History of Reaction		Presently Taking	Taken In the Past	History of Reaction
Anesthetics, Locally Injected	◻	◻	◻	Cortisone or Other Steroids	◻	◻	◻	Insulin or Diabetes Medications	◻	◻	◻
Anesthetics, General	◻	◻	◻	Coumadin, Heparin, Warfarin				Sedatives or Tranquilizers	◻	◻	◻
Antacids	◻	◻	◻	or other blood thinners	◻	◻	◻	Sleeping Pills (Barbiturates)	◻	◻	◻
Anti-anxiety Medications	◻	◻	◻	Dilantin	◻	◻	◻	Thyroid Medication such as Synthroid,			
Antidepressants	◻	◻	◻	Diuretics (water pills)	◻	◻	◻	Levoxyl or Levothyroxine	◻	◻	◻
Antihistamines	◻	◻	◻	Fen-phen (Ionimin, adipex, Fastin,				Tylenol (Acetomeniphen)	◻	◻	◻
Dally Aspirin Regimen	◻	◻	◻	phentermine, Pondimin, fenfluramine,				Adverse reaction to any other			
Birth Control Pills	◻	◻	◻	Redux, dexfenfluramine)	◻	◻	◻	medication or drugs'	◻ Yes		◻ No
Blood Pressure Medications	◻	◻	◻	Heart Medications such as Digoxin,				Please Specify:			
Codeine, Demerol or				Nitroglycerin or Digitalis	◻	◻	◻				
Other Analgesics	◻	◻	◻	Ibuprofen (Motrin)	◻	◻	◻				

List the other medications you are currently taking and what condition you are taking them for. Include vitamins, supplements, herbs and over the counter medications.

Medication	Condition	Proscribing Doctor

Pharmacy Name _____ Phone ( ) _____

Women: Are you pregnant? ◻ Yes ◻ No Nursing? ◻ Yes ◻ No Have you had any serious illnesses or surgeries? ◻Yes ◻ No If yes, describe_____

Check (X) your current use of:

Tobacco ◻ Yes ◻ No

Packs per day_____

Alcohol, Beer, Wine ◻Yes ◻ No

Drinks per day_____

Street Drugs ◻ Yes ◻ No

Times per day _____

Caffeine ◻ Yes ◻ No.

Cups per day _____

High Stress ◻ Yes ◻ No

Reason _____

Do you have any other health needs you should bring to our attention? _____

To the best of my knowledge, the above information is complete and correct I understand that it is my responsibility to inform my doctor if I, or my minor child, ever haver a change in health.

Signature of Patient, Parent, Guardian or Personal Representative:_____ Date

Please print name of Patient, Parent, Guardian or Persona) Representative_____ Relationship to Patient _____

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DENTAL HISTORY AND PATIENT GOALS

Date: _____ Patient Name: _____ Date of Birth: _____

Dental History

Dentist's Name: _____ Dental Clinic: _____ Phone Number: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Date of Last Appointment: _____ Date of Last X-Rays: _____

Why did you leave your previous dentist? _____

✓ Please Check Mark if you have or have had issues with any of the following:

___Bad Breath
___Bite Problems
___Biting Cheeks or Lips
___Bleeding Gums
___Burning Sensation on Tongue
___Chew on one side of Mouth
___Pain when Chewing
___Chewing on Foreign Objects
___Clicking or Popping Jaw
___Dry Mouth
____Fingernail Biting
____Food Collection Between the Teeth
____Grinding or Clenching Teeth
____Gums Swollen or Tender
___Jaw Pain or Fatigue
___Loose or Broken Fillings
____Loose or Broken Teeth
____Mouth Breathing
____Missing Teeth
____Opening or Closing of Jaw
___Orthodontic Treatment
____Pain around Ear
____Pain when Brushing Teeth
_____Periodontal Treatment
_____Prominent Gag Reflex
_____Pyorrhea or Trench Mouth
_____ Sensitivity to Cold
____ Sensitivity to Hot
____Sensitivity to Sweets
____Sensitivity to When Biting
____Shifting Position of Teeth
____Snoring
___Sores, Blisters, Growths on Lips or Mouth
____Stained Teeth
____Swallowing
____ Talking
____Thumb Sucking
____Tobacco Use
____ Tongue Thrusting
____ Wisdom Teeth Extracted

How often do you brush your teeth? _____ How often do you floss? _____

How often do you have your teeth cleaned? _____ How often do you change toothbrushes? _____

Patient Goals

What is your goal for dental treatment today?

_____

Are you in discomfort today? _____Yes or _____No Does dental treatment make you nervous? _____Yes or _____No

Are you pleased with the appearance of your teeth? ____Yes or ____No If no, please explain _____

_____

Do you like your smile? _____Yes or ____No If no, please explain _____

_____

Have you ever had a bad experience in a dental office? _____Yes or _____No If no, please explain _____

_____

How can we help improve your teeth and smile? _____

_____

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Potential Risks and Limitations of Dental Treatment

As a rule, excellent dental results can be achieved with informed and cooperative patients. Thus, the following is routinely supplied to anyone considering dental treatment in our office recognizing the benefits of a pleasing smile and healthy teeth. You should also be aware that dental treatment, like any treatment of the body, has some inherent risks and limitations. These risks and limitations usually do not contra-indicate treatment but should be considered in making the decision to submit to dental treatment.

Perfection is our goal. However, in dealing with human beings, and problems of growth and development, the ravages of dental disease, genetics, and patient cooperation, achieving perfection is not always possible. Often a functionally and esthetically adequate result must be accepted. We will do everything within our capacity to insure the best possible care.

Throughout life, teeth are constantly changing. Periodic examinations should be done so any disease can be treated promptly. Frequent professional visits are the best insurance against serious dental disease. Decay or gum disease can occur if patients do not brush and floss their teeth properly and thoroughly. Excellent oral hygiene and plaque removal is a must.

On rare occasions, the nerve of a tooth may die and become infected. A tooth that has been damaged by deep decay, a minor blow or extensive dental treatment can die over a long period of time. An undetected non-vital tooth may flare up during any dental treatment and may require endodontic (root canal) treatment to maintain it. It may even have to be removed. There is also a risk that during or following treatment soreness or tenderness may occur in the temporomandibular joints (lower jaw joints).

The total time for treatment can be delayed beyond our estimate. Treatment plans can change due to altered conditions which may surface during treatment. Decay which may appear small on x-ray, may be larger than anticipated resulting in much more extensive treatment.

Informed Consent

I understand that during treatment, occasionally any of the above issues may occur. These can include but are not necessarily limited to: pain (discomfort), tooth mobility, tooth decay, devitalization (nerve loss), tooth and/or jaw changes, and injury resulting from the use of high speed dental equipment.

I understand that alternative treatment will be explained (including the consequences of no treatment) as well as the preferred method of treatment for my mouth. I understand that for a successful result and to lessen the dangers of complication, the following conditions are essential on my part:

1. Excellent Oral Hygiene
2. Proper diet controls
3. Strict adherence to instructions
4. Cooperation in keeping appointments

I understand that there is no warranty or guarantee to my result and/or care. I also understand that I can, at any time, ask for and receive a full recital of all possible risk related to my treatment.

In addition, I understand that treatment may be discontinued for patients who fail two appointments without prior notification; who are constantly late for their appointments; who continue to excessively cancel their appointments; who fail to practice acceptable oral hygiene; or who are uncooperative with staff providing care.

Date: _____ X_____

Signature of Patient, Guardian, Responsible Party (over age 18)

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FINANCIAL POLICY AND PRIVACY AGREEMENT

When we begin treatment, we make a commitment to provide you with the finest dental services possible. We are striving to help to create and preserve beautiful smiles for a lifetime.

INSURANCE

If you have dental insurance, we will do our best to estimate what your insurance will cover and ask you to pay what we estimate your insurance will not cover. This is only an estimate; we cannot understand completely the specifics of every insurance plan and the variations to each one. Because of this, there may be a balance owed by you after the insurance has paid, or you may also have a credit. You have our pledge that we will do our best to estimate as accurately as possible. You will be responsible for any balance your insurance does not cover.

DUAL INSURANCE

If you have dual insurance coverage, we cannot accurately estimate what the secondary insurance will pay and due to the time that it takes the secondary insurance to pay, it can become very confusing for everyone. Because of this, we will file the secondary insurance for you, however if secondary insurance does not pay within 30 days of filing, we will ask for you to cover the balance due and follow up with secondary insurance.

PAYMENT OPTIONS

You may pay as you go—meaning pay your portion when the service is rendered. Some procedures may require multiple visits and you can split your portion over those visits. We may also be able to phase treatment such that it can become more affordable. We accept most credit cards, checks, and cash.

5% DISCOUNT

If your treatment is over $1750 and if you pay in full at the beginning of treatment only with check or cash, you will be eligible for a 5% discount. If you have insurance, to be eligible for this discount, you will need to pay the entire amount less the 5% discount and the insurance payment will be sent to you.

CARE CREDIT

Our office has entered into an agreement with CARE CREDIT to offer a six-month interest free payment option to qualified applicants.

COLLECTION FEES

Any and all fees that are generated by any liens filed or accounts turned over to the collection agency, is your responsibility.

I have read the above and my preferred method of payment is: (please circle)

MasterCard Visa American Express Discover Card Cash Personal Check Care Credit

Signature: _____ Date_____

RELEASE OF INFORMATION FOR INSURANCE AND REFFERALS

I authorize release of information to any referred physician, financially responsible party, insurance company, or federal payer as is appropriate for billing and receiving payments for any and all dental services provided from Christian R. Willard, D.D.S. and its personnel.

Signature: _____ Date_____

Insurance Disclaimer

(Please read carefully)

ONLY FOR PATIENTS FILING DENTAL INSURANCE

Please note we do not accept nor participate with any DMO insurance plans, prepay plans, or Medicaid.

******DR. WILLARD DOES NOT PARTICIPATE WITH ANY MEDICARE PLANS******

Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services. When we call on your insurance and verify benefits it is not a guarantee of payment by the insurance company and may vary according to your individual plan when the actual claim is submitted.

Estimates proposed at our office are only an estimate of what your insurance coverage will be. Estimates are not a guarantee. If you need **exact** payment of benefits, then a pre-determination is required. If you would like this done, you must specify this with the front desk staff **before** any work is initiated. **(This may take up to 8 weeks).**

Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance company. Regardless of coverage, your estimated co-payment is due in full the day of treatment. **If your insurance plan does not pay within 120 days of treatment, you must pay any outstanding balance and seek reimbursement from your dental plan**. If your dental plan pays more than expected, you will receive a refund check. Also remember dental insurance plans may not cover all of your dental needs.

By signing below I am acknowledging that I have chosen to allow ***Dr. Christian Willard*** to file my insurance and accept full responsibility for this account and for all dentistry performed upon my family in this dental office. I understand it is my responsibility to be aware of what type of dental plan I have. I also understand this office cannot guarantee my insurance company will cover all services rendered and it is only an estimate of benefits. I also understand that if my insurance company does not pay within **120 days** of my date of service then I will become responsible to pay at that time.

Print Name: _____ **Date:** _____

Patient / Responsible Party Signature:

_____

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PRIVACY PRACTICES ACKNOWLEDGEMENT (HIPAA)

I have received the Notice of Privacy Practices and I have been provided the opportunity to review it.

Print Name: _____ Birthday: _____

Signature_____ Date: _____

TCPA CONSENT

You agree, in order for us to service our account or to collect any amounts you may owe, our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency, may contact you by telephone at any telephone number associated with your account. Including wireless telephone numbers, which could result in charges to you. Our organization's representatives, ancillary providers, HIPAA business associates, vendors, and the representatives of our debt collection agency may also contact you by sending text messages or emails, using any email address you provide to us. Methods of contact may include using prerecorded/artificial voice messages and/or use of an automatic dialing device, as applicable. I/We have read this disclosure and agree that the Lender/Creditor, its ancillary providers, HIPAA business associates, vendors, and its debt collection agents may contact me/us as described above.

Print Name: _____ Date: _____

Signature: _____

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Name: _____

Date: _____

I would prefer to be notified of my upcoming appointments by the following:

(Please indicate which of these applies to your preference. You may choose as many as you like.)

Text Message# (_____) _____

E-Mail: _____@_____

Phone Call# (_____) _____

Signature: _____