MEDICAL HISTORY QUESTIONARE

Name _____ ( ) M ( ) F Date of Birth: _____

Address: _____ City, State, Zip: _____

Contact: Home Phone _____ Cell Phone _____ Work Phone _____

Email Address: _____

What is your estimate of your current health? ( ) Poor ( ) Fair ( ) Good

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO		YES	NO
Hospitalization for illness or injury	☐	☐	Stomach or duodenal ulcer.....	☐	☐
Allergic reaction to:			Diabetes.....	☐	☐
• Aspirin, Ibuprofen.....	☐	☐	Glaucoma.....	☐	☐
• Acetaminophen.....	☐	☐	Head or neck injury.....	☐	☐
• Penicillin.....	☐	☐	Epilepsy, convulsions (seizures)..	☐	☐
• Sulfa.....	☐	☐	Viral infections or cold sores.....	☐	☐
• Codeine.....	☐	☐	Lumps or swelling in the mouth...	☐	☐
• Sedative.....	☐	☐	Hives, skin rash, hay fever.....	☐	☐
• Local Anesthetics.....	☐	☐	Hepatitis (type __).....	☐	☐
• Latex.....	☐	☐	HIV / AIDS.....	☐	☐
• Metals.....	☐	☐	Tumor or abnormal growth.....	☐	☐
• Any other allergies.....	☐	☐	Radiation therapy.....	☐	☐
			Chemotherapy.....	☐	☐
Heart murmur/problems.....	☐	☐	Psychiatric treatment.....	☐	☐
Rheumatic fever.....	☐	☐	Antidepressant treatment.....	☐	☐
Blood pressure HIGH / LOW.....	☐	☐	Alcohol or drug dependency.....	☐	☐
Pacemaker.....	☐	☐	Taken steroids in the last 2 years...	☐	☐
Stroke.....	☐	☐	Ever taken Bisphosphonates (IV or Oral	☐	☐
Artificial joint or heart valve.....	☐	☐	(Actonel, Bonica, Fosamax, Skelid, Didronel, Aredia, Zometa, Bonefos)		
Date of placement _____			ARE YOU:		
Anemia or other blood disorders.....	☐	☐	Presently being treated for illness....	☐	☐
Prolonged bleeding due to slight cut.....	☐	☐	Aware of a change in your health.....	☐	☐
Tuberculosis.....	☐	☐	Often exhausted or fatigued.....	☐	☐
Asthma/Emphysema.....	☐	☐	Subject to frequent headaches.....	☐	☐
Sinus problems.....	☐	☐	A smoker – *How many per day?*____	☐	☐
Kidney disease.....	☐	☐	Using a CPAP?	☐	☐
Jaundice or Liver disease.....	☐	☐	Are you anxious about dentistry.....	☐	☐
Thyroid or parathyroid disease.....	☐	☐	FEMALE – use birth control pills....	☐	☐
Hormone deficiency.....	☐	☐	FEMALE – pregnant.....	☐	☐
High cholesterol.....	☐	☐	MALE – have prostate disorder.....	☐	☐

Please describe any current medical treatment, impending or recent surgery, or other treatment that may possibly affect your dental treatment. _____

_____

List (or attach a separate list if extensive) any medications taken within the last two years.

_____

_____

UPDATE -- PLEASE ADVISE US OF ANY CHANGE IN YOUR MEDICAL HISTORY AND MEDICATIONS

SIGNATURE _____ **DATE** _____

Initial _____ **Date** _____ **Initial** _____ **Date** _____ **Initial** _____ **Date** _____

DENTAL HISTORY

Referred by _____

Previous dentist _____ How long? _____

Last dental exam _____ Last dental x-ray _____

Last dental treatment _____

How often do you have your teeth cleaned? 3 mo _____ 4 mo _____ 6 mo _____ 1 year or longer _____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
1. Unhappy with the appearance of your teeth	☐	☐
2. Unfavorable dental experiences	☐	☐
3. Dental fears	☐	☐
4. Problems with effectiveness or bad reactions to dental anesthetic	☐	☐
5. Orthodontic treatment (braces) / when	☐	☐
6. Periodontal (gum) treatment / when	☐	☐
7. Bleeding gums	☐	☐
8. Avoid brushing any part of your mouth	☐	☐
9. Part of your mouth is sensitive to temperature	☐	☐
10. Sore teeth	☐	☐
11. A burning sensation in your mouth	☐	☐
12. Difficulty swallowing	☐	☐
13. An unpleasant taste or odor in your mouth	☐	☐
14. Dry mouth	☐	☐
15. Jaw problems (Temporomandibular joint)	☐	☐
16. Difficulty opening your mouth widely	☐	☐
17. Stiff neck muscles	☐	☐
18. Awaken with an awareness of your teeth or jaws	☐	☐
19. Tension headaches	☐	☐
20. Clench or grind your teeth	☐	☐
21. Do you wear a night guard at night	☐	☐
22. Lost any teeth	☐	☐
23. Do you sweat or tremble a lot during examination	☐	☐
24. Do unfamiliar people or places make you uncomfortable	☐	☐
25. Are you happy with the color of your teeth	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check yes or no)
☐	☐	Has your present denture been relined? When? _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____
		When did you receive your first partial of complete denture? _____
		How long have you worn your present denture? _____

Patient's Signature _____ Date _____

Person Responsible for Payment

Name: _____
Last First Middle

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

E-mail Address: _____

How would you like us to confirm your appointments? (Circle) Email Home Work Cell

Marital Status (Circle): Single Married Separated Divorced Widowed

Social Security #: _____ Sex (Circle): Male Female Birth Date: _____

Relationship to Patient (Circle): Self Spouse Child Other _____

Emergency Contact: _____
Name Address Phone #

Insurance

Primary Dental Insurance: _____ Subscriber Name: _____

ID #: _____ Birthdate: _____ Group #: _____ Employer: _____

Dental Insurance Mailing Address: _____

Secondary Dental Insurance: _____ Subscriber Name: _____

ID #: _____ Birthdate: _____ Group #: _____ Employer: _____

Dental Insurance Mailing Address: _____

I authorize the release of any medical or other information necessary to process my claims as well as payment of dental benefits to Dr. Wadhwani for services rendered. This authorization shall remain valid until such time as I request otherwise. _____

Office Financial Policy

I understand that payment in full is expected at the time of service for all appointments. Payment can be made by cash, check, or major credit card. Because we are a specialty office, many of our procedures fall into the category of elective dentistry and are not covered by insurance. We accept all PPO insurance plans, but are not contracted directly with any insurance company and are considered an out-of-network provider. All other insurance claims (including medical and accident claims) are the responsibility of the patient. Accounts over 30 days will accrue a monthly service charge of 1%. Unresolved accounts over 90 days due will be sent to a collection agency, interest and fees will be included.

Signature _____ Date _____

Chandur Wadhwani, DDS, MSD

12715 BEL RED RD SUITE 201 | BELLEVUE WA, 98005 | (425) 453-1117

Written Financial Policy

Thank you for choosing Chandur Wadhwani, DDS, MSD. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

KINDLY NOTE: PAYMENT IS DUE AT TIME OF SERVICE. FOR MORE COMPREHENSIVE TREATMENT PLANS, A 50% DEPOSIT IS REQUIRED AT INITIAL APPOINTMENT.

Payment Options:

You can choose from:

- Cash, Check and All Major Credit Cards

  (We offer a 3% courtesy to patients who pay for their treatment with **Cash or Check** at the beginning of care for treatment plans of $1000 or above.)

- We also offer in-house financing, with payments for services spread equally over 3 months with automatic credit card processing.

- Convenient Monthly Payment Options[1] through CareCredit or Lending Club Patient Financing for treatment of $1000 or above, however payment in full at commencement of treatment is required when using this option.
  - Allows you to pay over time
  - No annual fees or pre-payment penalties

Please note:

Chandur Wadhwani, DDS, MSD requires payment in full prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

For patients with dental insurance we are happy to work with your carrier to maximize your benefit and provide them with documentation they need to receive reimbursement for your treatment.

We charge 12% APR interest on all past due accounts. There is a $25 fee for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1]Subject to credit approval

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGMENT

By my signature below, I acknowledge that I have read and understand the Notice of Privacy Practices of NW Prosthodontics. I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.
- Photos, slides, x-rays or any other viewings of my care and treatment during or after its completion to be used for the advancement of dentistry and reimbursement purposes. My identity will not be revealed to the general public, however, without my permission

Patient or legally authorized individual signature _____ Date _____

Printed name if signed on behalf of the patient _____ Relationship _____

Returning Patients:

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

Signature _____ Date _____

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other_____

MISSED APPOINTMENT POLICY

We require a two-day business days advanced notice for any changes or cancellations of your appointments. This allows us the time we initially reserved especially for you in our schedule to be filled by another patient. As a courtesy, we make every effort to remind you of your appointments ahead of time; however, it is ultimately your responsibility to keep your appointments.

We reserve the right to charge a fee for late cancellations and missed appointments to help cover the cost of our operational expenses.

By signing below, I acknowledge that I have read and agree to the above policy.

Signature_____ Date_____

WHAT IS THE BEST WAY TO CONFIRM YOUR APPOINTMENTS?

Home / Work / Cell / E-mail _____