WICKLUND DENTAL
Personalized and comfortable dentistry for all ages

PATIENT REGISTRATION

Welcome! We want to provide you with the best possible care. Please assist us by thoroughly answering all the questions below. All information is completely confidential.

Name _____ Birth date _____ Age _____ SSN _____

Preferred name _____ Email Address _____

Mailing Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Employer _____

Insurance Company _____ Group No. _____ Insurance I.D. No. _____

Spouse's Name (if married) _____ Birth date _____ Age _____ SSN _____

Preferred name _____ Email Address _____

Mailing Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____ Employer _____

Insurance Company _____ Group No. _____ Insurance I.D. No. _____

Emergency Contact _____ Phone _____ Relation _____

BILLING INFORMATION

Person responsible for account _____ Relationship to patient _____

Preferred name _____ Email Address _____

Mailing Address _____ City _____ State _____ Zip _____

Primary Phone _____ Secondary Phone _____

If paying with bank card: Card No. _____ Exp. Date _____

Who may we thank for referring you? _____

Signature _____ Date _____

this space is intentionally left blank

CONSENT FOR TREATMENT

I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient)_____'s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetics, sedatives, and other medication as necessary. I fully understand that using anesthetic agents or medication carries certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and that a notice fully outlining the protection of my personal health information is available.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a late charge (12% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's signature_____ Date _____

Parent/Responsible party's signature _____ Relationship to Patient _____

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DENTAL HISTORY

Name _____ Birth date _____ Age _____ Date _____

Please answer each of the following questions.

1. Reason for appointment _____

2. Date of last dental visit _____ Last Cleaning _____ X-Rays _____

Previous dentist's name _____ Phone _____

Address _____ State _____ Zip _____

3. Do you have any dental problems now? ☐ **YES** ☐ **NO** If yes, please describe _____

4. What issues do you want to address today? _____

	YES	NO
Are your teeth sensitive?	☐	☐
If yes, please describe _____		
Have either of your biological parents experienced gum disease or tooth loss?	☐	☐
Do you frequently get cold sores, blisters or other oral lesions?	☐	☐
Have you noticed loose teeth or any change in your bite?	☐	☐
Does food tend to be caught in between your teeth?	☐	☐
If yes, where? _____		
Do you clench or grind your teeth while awake or asleep?	☐	☐
Do you breathe through your mouth?	☐	☐
Do you have tired jaws, especially in the morning?	☐	☐
Do you snore or have sleeping disorders?	☐	☐
Do you smoke/chew tobacco or use other products?	☐	☐
Have you seen a dental specialist?	☐	☐
Have you had a serious injury to the mouth or head?	☐	☐
If yes, please describe _____		

	YES	NO
Have you experienced clicking or popping of the jaw?	☐	☐
Have you experienced pain? (joint, ear, side of face)	☐	☐
Have you experienced difficulty in opening/closing mouth?	☐	☐
Have you experienced head, neck or shoulder aches?	☐	☐
Have you experienced sore muscles?	☐	☐
Do you feel nervous about having a dental treatment?	☐	☐
If yes, please describe _____		
_____		
_____		
Have you ever had an upsetting dental experience?	☐	☐
If yes, please describe _____		
_____		
_____		
What can we do to make your dental visits more pleasant?		
Please describe _____		
_____		

5. What are your long term desires for your teeth/dental health? _____

_____

6. Have you ever been told that you needed to be pre-medicated with antibiotics prior to treatment? ☐ **YES** ☐ **NO**

7. Rate the health of your mouth now **POOR** **1** **2** **3** **4** **5** **EXCELLENT**

8. Rate the satisfaction of your smile **UNSATISFIED** **1** **2** **3** **4** **5** **HIGHLY SATISFIED**

For doctor/staff use only:

HEALTH HISTORY

Please answer each question as completely as you can.

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Name _____ Birth Date _____ Age _____

1. Are you in good health now? ☐ **YES** ☐ **NO** Describe: _____

2. Are you under the care of a physician? ☐ **YES** ☐ **NO** If so, what is the condition being treated? _____

_____

3. Physician's name _____ Physician's phone _____

4. Do you have, or have you ever had, any of the following?

	YES	NO
GENERAL		
Tire easily, weakness	☐	☐
Marked weight change	☐	☐
On a diet	☐	☐
Supervised diet	☐	☐
Night sweats	☐	☐
Insomnia	☐	☐
SKIN		
Rash/hives	☐	☐
Change skin color	☐	☐
EYES		
Visual change	☐	☐
Glaucoma	☐	☐
EARS		
Loss of hearing	☐	☐
Ringing in ears	☐	☐
NOSE		
Frequent nosebleeds	☐	☐
Sinus problems	☐	☐
THROAT		
Soreness/hoarseness	☐	☐

	YES	NO
NERVOUS SYSTEM		
Stroke	☐	☐
Headaches	☐	☐
Convulsions/epilepsy	☐	☐
Numbness/tingling	☐	☐
Dizziness/fainting	☐	☐
Psychiatric treatment	☐	☐
RESPIRATORY		
Tuberculosis	☐	☐
Emphysema	☐	☐
Asthma/hayfever	☐	☐
Persistent cough	☐	☐
Bloody sputum	☐	☐
Difficulty breathing while lying down	☐	☐
ENDOCTRINE		
Diabetes	☐	☐
Family history of diabetes	☐	☐
Thyroid condition/goiter	☐	☐
HEART/BLOOD VESSELS		
Rheumatic fever	☐	☐
Heart murmur	☐	☐
Chest pain/discomfort	☐	☐

	YES	NO
Heart attack/trouble	☐	☐
Shortness of breath	☐	☐
Swelling of ankles	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐
Congenital heart disease	☐	☐
Artificial heart valve	☐	☐
Pacemaker	☐	☐
Heart surgery	☐	☐
Other	☐	☐
BONE/MUSCLES		
Arthritis/rheumatism	☐	☐
Artificial joints	☐	☐
DIGESTIVE SYSTEM		
Hepatitis	☐	☐
Jaundice	☐	☐
Ulcers	☐	☐
Change in appetite	☐	☐
URINARY		
Kidney disease	☐	☐
Increase in frequency of urination	☐	☐
Bloody urine	☐	☐
Venereal disease	☐	☐

	YES	NO
BLOOD		
Bruise easily	☐	☐
Anemia	☐	☐
Blood transfusions	☐	☐
OTHER		
Radiation therapy	☐	☐
Tumors or growths	☐	☐
Cancer	☐	☐
2+ drinks/day	☐	☐
Alcohol dependency	☐	☐
Tobacco dependency	☐	☐
Drug dependency	☐	☐
AIDS/ARC, HIV	☐	☐
Ever had a serious illness	☐	☐
Ever had a serious accident	☐	☐
Ever had excessive bleeding after extraction	☐	☐
Cuts take long time to heal	☐	☐

5. Are you pregnant? ☐ **YES** ☐ **NO** Month? _____ **6.** Are you taking birth control pills? ☐ **YES** ☐ **NO**

7. Have you ever experienced an allergic reaction to:

	YES	NO
Local anesthetics (e.g. novocaine)	☐	☐
Barbituates/sedatives/sleeping pills	☐	☐
Penicillin/sulfa/other antibiotics	☐	☐
Aspirin or codeine	☐	☐
Latex	☐	☐

Other allergies _____

8. Are you taking any of the following?

	YES	NO
Antibiotics/sulfa drugs	☐	☐
Blood thinners	☐	☐
Blood pressure medication	☐	☐
Thyroid medication	☐	☐
Cortisone/steroids	☐	☐
Antihistimines/allergy drugs cold remedies	☐	☐

	YES	NO
Insulin/other diabetes drugs	☐	☐
Recreational drugs	☐	☐
Digitalis/other heart medications	☐	☐
Nitroglycerin	☐	☐
Aspirin/ibuprofen/acetaminophen	☐	☐
Fossamax, Boniva, Actonel, Zometa?	☐	☐
Other medication	☐	☐

If yes to any of the above, list name of medication(s) and dosage(s): _____

_____

9. Do you have any disease, disability, condition or problem not listed above, which we should know about? ☐ **YES** ☐ **NO**

If yes, please explain _____

Signature of Patient (or Parent or Guardian) _____ Date _____

For doctor/staff use only:

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FINANCIAL POLICY

Lance F. Wicklund, DMD, PLLC

Dental treatment is an investment in your general and dental health. To assist you in making financial arrangements and submitting your insurance claims we will work with you to make financial arrangements as simple as possible.

Payment for services is due at the time they are performed unless you have a prearranged financial payment plan with our office.

If you have dental insurance, please remember that you need to understand the provisions and limitations of your plan. Reading your insurance plan booklet and talking directly with your insurance company are the best ways to inform you of the services the plan covers. Doing so before treatment begins will help prevent many misunderstandings.

Insurance companies have set a trend of continuing to decrease the number and percentage of covered services without informing dental providers. Please remember that your dental insurance is a contract between you and your insurance company and that you are ultimately responsible for the charges not covered by the insurance plan. Thank you for your understanding.

As a courtesy to you, we will bill your insurance company directly. We require payment of your share of the treatment charges at each appointment. If we do not receive payment from your insurance in 90 days, the balance is then your responsibility and due in full. If your insurance plan should pay more than the estimated costs we will send you a refund within 90 days of the insurance payment.

We accept cash, checks, VISA, MasterCard and Discover.
We charge interest at 12% per month after 90 days.
We charge $25.00 for a returned check from your bank.
Because we schedule individual time with each client we ask for a 24 hour notice if you are unable to make your appointment. A $75.00 fee will be assessed for missed appointments.

We believe regular visits and preventive treatment are your best protection against long and costly procedures. However, when the costs of necessary treatment exceed your budget, our front office can help you create a financial payment plan prior to beginning treatment.

If you have questions, please contact Wendy or Monica at our front desk.

Patient Signature date
(Person responsible for account for minors)

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PRIVACY PRACTICES

Patient Record of Disclosures & Acknowledgement

The HIPAA Privacy Rule gives patients the right to request a restriction on the uses and disclosures of their protected dental health information (PHI). Patients are also provided the right to request confidential communication or that a communication of PHI be made by alternative means, such as sending correspondence to the patient's office instead of their home. Our Statement of Privacy Practices describes in more detail how your dental health information may be used and disclosed, and how you can access your information. Please read our Statement on the wall near the front desk.

I wish to be contacted in the following manner (check all that apply):

Home telephone
☐ OK to leave message with detailed information
☐ Leave message with callback only

Work phone
☐ OK to leave message with detailed information
☐ Leave message with callback only

Cell phone
☐ OK to leave message with detailed information
☐ Leave message with callback only

Written Communication
☐ OK to mail to my home address
☐ OK to mail to my work address
☐ OK to E-mail information to me

Additional Disclosure Authority
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

Any member of my immediate family: ☐ **YES** ☐ **NO**

Spouse Only: ☐ **YES** ☐ **NO**

Other (Please Specify): _____

Patient Signature _____ Date _____

Print Name _____

The Privacy Rule generally requires dental healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the patient.

NOTE: Uses and disclosures may be permitted without prior consent in an emergency.