PATIENT NAME	
EMERGENCY CONTACT	

MEDICAL HISTORY

1. Please give the name of your regular physician: _____ Phone: (_____)_____

   Address _____

2. Are you under the care of any other physician(s) or specialists at this time? Yes No If yes, please list the name of the physician and why you are under care:

   _____

3. Are you taking any medication, drugs or pills now? Yes No If yes, please list name and dosage:

   _____ _____

   _____ _____

   _____ _____

   _____ _____

4. Are you allergic to any of the following?

   ❑ Aspirin ❑ Penicillin ❑ Codeine ❑ Local Anesthetics ❑ Acrylic ❑ Metal ❑ Latex ❑ Sulfa Drugs ❑ Other

   If yes, please explain reaction: _____

5. Indicate which of the following you have had, or have at present. Circle "yes" or "no" to each item.

Heart (Surgery, Disease, Attack)	Yes	No	Ulcers	Yes	No	Hepatitis A (infectious) B (serum)	Yes	No
Chest Pain	Yes	No	Diabetes	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disease	Yes	No	Thyroid Problems	Yes	No	A.I.D.S	Yes	No
Heart Murmur	Yes	No	Glaucoma	Yes	No	H.I.V. Positive	Yes	No
High Blood Pressure	Yes	No	Contact lenses	Yes	No	Cold Sores/Fever Blisters	Yes	No
Mitral Valve Prolapse	Yes	No	Emphysema	Yes	No	Blood Transfusion	Yes	No
Artificial Heart Valve	Yes	No	Chronic Cough	Yes	No	Hemophilia	Yes	No
Heart Pacemaker	Yes	No	Tuberculosis	Yes	No	Sickle Cell Disease	Yes	No
Rheumatic Fever	Yes	No	Asthma	Yes	No	Bruise Easily	Yes	No
Arthritis/Rheumatism	Yes	No	Acid Reflux / Heartburn	Yes	No	Liver Disease	Yes	No
Cortisone Medicine	Yes	No	Latex Sensitivity	Yes	No	Yellow Jaundice	Yes	No
Swollen Ankles	Yes	No	Seasonal Allergies	Yes	No	Neurological Disorders	Yes	No
Stroke	Yes	No	Sinus Trouble	Yes	No	Epilepsy or Seizures	Yes	No
Diet (Special/Restricted)	Yes	No	Radiation Therapy	Yes	No	Fainting or Dizzy Spells	Yes	No
Artificial Joints (hip, knee, etc.)	Yes	No	Chemotherapy	Yes	No	Nervous/Anxious	Yes	No
Kidney Trouble	Yes	No	Tumors	Yes	No	Psychiatric/Psychological Care	Yes	No

6. Do you have or have you had any disease, condition, or problem not listed? Yes No

   If yes, please list: _____

7. **Women.** Are you: **Pregnant**? Yes, ___Months No **Nursing**? Yes No **Taking birth control pills**? Yes No
8. Do you use tobacco products? Yes No ❑ Chew ❑ Smoke How many years have you been using?_____
9. Are you concerned about bad taste or breath? Yes No
10. Have you been advised to take antibiotic premed prior to dental tx artificial joint (in last 2 years) or heart valve replacement?

    Yes No Other _____
11. Have you had surgery recently or been hospitalized? Yes No Why _____
12. Have you had Botox or Dermal Fillers? Yes No
13. Are you interested in Botox or Dermal Fillers? Yes No

Notes

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may realease such information to you. I will notify the doctor of change in my health or medication.

Patient/Guardian Signature_____ Date_____

Dentist Signature_____ Date_____

AUTHORIZATION FOR USE AND/OR RELEASE OF INFORMATION:

Below, list the names of any individuals/organizations that you authorize the employees of Dr. Brad Welsh & Associates to share/disclose your protected health information (PHI) with. For example: name, radiographs, progress notes, prescriptions, photographs, images, etc.

1. Name: _____ Relationship: _____
2. Name: _____ Relationship: _____

I further authorize this information to be shared and discussed with: the aforementioned; my dental and/or medical insurance company; and myself by, including but not limited to: telephone, facsimile, unencrypted and/or encrypted email, encrypted and/or unencrypted portable storage media (e.g. CD, thumb dive, portable hard-drive, etc.) and/or by conventional mail, and I hereby authorize the aforementioned parties to discuss my PHI with employees of Dr. Brad Welsh & Associates in the same manner. I understand that some of these listed forms of communication are not secure and may be intercepted by unintended parties. If I have any objection to the sending of my PHI through unsecure channels and/or specifically desire that my PHI not be shared through unencrypted email, then I would not sign this Authorization. The Authorization for release of information from Dr. Brad Welsh & Associates covers all past, present and future periods of time or which I choose to revoke said authorization in writing.

I understand that I have the right to revoke this Authorization from an or all of the aforementioned entities independently.

I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned by any employee of Dr. Brad Welsh & Associates on whether or not I sign this Authorization.

I understand that information used or disclosed pursuant to this Authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ _____ _____

Printed name Signature Date

_____ _____

Relationship to patient if other than patient Patient's Name

_____ I give consent for Dr. Brad Welsh & Associates to leave a message on my answering machine and/or voicemail that could include personal health information for myself or one of my dependents (if applicable)

Patient Registration

CONFIDENTIAL

Patient Information

Name_____ (_____) Date of Birth_____
First MI Last Nickname

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

E-Mail Address_____ I prefer to be called at ❑Home ❑Work ❑Cell ❑Any

Are you: ❑Male ❑Female

❑Minor_____ ❑Single ❑Married_____ ❑Divorced ❑Separated ❑Widowed
Parents' names Spouse's name

Employer (or School, if minor)_____ Occupation_____

Social Security Number_____ Whom may we thank for referring you?_____

Other Family members in the practice:_____

Person to contact in case of an emergency:_____
Name Phone Relationship

Responsible Party

Complete this section if responsible party is someone other than the patient.

Name_____ Date of Birth_____ Relationship to patient_____
First Last

Social Security Number_____ Employer_____
Name Phone

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell_____

Currently a patient in this office? ❑Yes ❑no

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 2.5% (25% APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made.

Responsible Party's Signature_____ Date_____

Dental Benefit Information

If you have no dental benefits disregard this section.

Primary Plan

Name of Policy Holder_____
Address_____
Phone_____ E-Mail_____
Birthdate_____ Relationship to patient_____
Social Security Number_____
Employer_____
Insurance Co. Name_____
Insurance Co. Address_____
Group Number_____ ID #_____

Secondary Plan

Name of Policy Holder_____
Address_____
Phone_____ E-Mail_____
Birthdate_____ Relationship to patient_____
Social Security Number_____
Employer_____
Insurance Co. Name_____
Insurance Co. Address_____
Group Number_____ ID #_____

I hereby authorize benefit payment directly to Dr. Brad Welsh's Office. I authorize this office to release any information my insurance company asks for, such as radiographs, dental history, and office/clinical notes. I understand that I am ultimately responsible for all costs of dental treatment.

Primary Policy Holder Signature: _____ Secondary Policy Holder Signature: _____

Financial Responsibility Notice

Customers with an outstanding balance of 90 days or more must make arrangements for payment to our office. It is known to me that should I fail to pay unpaid charges for more than 90 days, my account may be reviewed for further collection action. If I default and my account is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed including court costs and attorney fees.

Signature: _____

Dr. Brad Welsh & Associates, Inc. Office Financial Guidelines

Thank you for choosing Dr. Brad Welsh & Associates. The following are our financial guidelines. Please review, initial where indicated, sign and date at the bottom.

Insurance:

As a courtesy to our insured patients, we submit claims to your insurance company free of charge. We will help you receive your maximum allowable benefits.

Our doctors will diagnose treatment based on your dental health not your insurance coverage.

We will forward any items that the insurance company may request and help in any way we can to get your claim paid. If insurance is requesting information from you; we will contact you and it is your responsibility to get the insurance company the information they require to process your claim. If your insurance has not paid within 90 days of services rendered, you will need to make full payment to this office and be reimbursed when your insurance company pays. After 90 days you are responsible to pursue payment from the insurance company.

INITIAL: _____

Account Balance:

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I agree that payment is due at the time of service unless other arrangements have been made. I agree that I am responsible for payment of all services rendered regardless of insurance coverage, if applicable. I understand that a 3% (36%APR) late fee may be added to any account balance over 60 days. If required, I also understand that a credit history inquiry may be made. There will be a $30.00 charge for returned checks. Failure to keep agreed financial arrangements can be cause for the cancellation of any future appointments.

INITIAL: _____

Missed Appointments:

In order to serve you better and reduce the cost of dental care, we try to maintain an efficient appointment system. However, our cost of providing care increases greatly when people fail to keep scheduled appointments or cancel at the last minute. We require at least 24 hours notice for any cancelled appointment. If an appointment is missed or cancelled in less than 24 hours, we reserve the right to charge a broken appointment fee of $50.00. We realize there are sometimes extenuating circumstances that will keep you from keeping a dental appointment. That is taken into consideration prior to charging the broken appointment fee.

INITIAL: _____

Patient Responsibilities:

Discourteous, rude or inappropriate behavior toward our doctors and/or staff can be cause for immediate termination of the relationship with this office.

INITIAL: _____

My signature below indicates that I have read and agree to the above written financial guidelines of Dr. Brad Welsh & Associates.

Signature of Responsible Party/Date:_____