George P. Wick, DDS

1234 OLD HENDERSON RD. COLUMBUS, OH 43220 P: (614) 268-9443 GEORGEWICKDDS@GMAIL.COM

PATIENT REGISTRATION

First Name:_____ Last Name:_____

Address:_____ City, State, Zip:_____

Home #:_____ Cell #:_____ Preferred contact #: HOME or CELL

Work #:_____Ext:_____ Email address:_____

Birthdate:_____ Social Security #:_____ Driver's License #:_____

Emergency Contact:_____ Phone number:_____

RESPONSIBLE PARTY (if someone other than the patient)

First Name:_____ Last Name:_____

Address:_____ City, State, Zip:_____

Home #:_____ Cell #:_____ Preferred contact #: HOME or CELL

Work #:_____Ext:_____ Email address:_____

Birthdate:_____ Social Security #:_____ Driver's License #:_____

INSURANCE INFORMATION

Name of Insured:_____ Relationship to patient: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Sec. #:_____ Insured DOB:_____ Employer:_____

Insurance Company:_____ Contact number: _____

Claims Mailing Address:_____ City, State, Zip:_____

Thank you so much for filling out these forms.
It will help us provide you with the best possible care.

Time 9:53 AM

Dr. George P. Wick

Date 2/2/2016

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	○ Yes ○ No	If yes
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes
Are you on a special diet?	○ Yes ○ No	
Do you use tobacco?	○ Yes ○ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other?	☐	If yes
Do you use controlled substances?	○ Yes ○ No	If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Cortisone Medicine	○ Yes ○ No	Hemophilia	○ Yes ○ No	Radiation Treatments	○ Yes ○ No
Alzheimer's Disease	○ Yes ○ No	Diabetes	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Recent Weight Loss	○ Yes ○ No
Anaphylaxis	○ Yes ○ No	Drug Addiction	○ Yes ○ No	Hepatitis B or C	○ Yes ○ No	Renal Dialysis	○ Yes ○ No
Anemia	○ Yes ○ No	Easily Winded	○ Yes ○ No	Herpes	○ Yes ○ No	Rheumatic Fever	○ Yes ○ No
Angina	○ Yes ○ No	Emphysema	○ Yes ○ No	High Blood Pressure	○ Yes ○ No	Rheumatism	○ Yes ○ No
Arthritis/Gout	○ Yes ○ No	Epilepsy or Seizures	○ Yes ○ No	High Cholesterol	○ Yes ○ No	Scarlet Fever	○ Yes ○ No
Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No	Shingles	○ Yes ○ No
Artificial Joint	○ Yes ○ No	Excessive Thirst	○ Yes ○ No	Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No
Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No	Irregular Heartbeat	○ Yes ○ No	Sinus Trouble	○ Yes ○ No
Blood Disease	○ Yes ○ No	Frequent Cough	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Spina Bifida	○ Yes ○ No
Blood Transfusion	○ Yes ○ No	Frequent Diarrhea	○ Yes ○ No	Leukemia	○ Yes ○ No	Stomach/Intestinal Disease	○ Yes ○ No
Breathing Problems	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Stroke	○ Yes ○ No
Bruise Easily	○ Yes ○ No	Genital Herpes	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No	Swelling of Limbs	○ Yes ○ No
Cancer	○ Yes ○ No	Glaucoma	○ Yes ○ No	Lung Disease	○ Yes ○ No	Thyroid Disease	○ Yes ○ No
Chemotherapy	○ Yes ○ No	Hay Fever	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Chest Pains	○ Yes ○ No	Heart Attack/Failure	○ Yes ○ No	Osteoporosis	○ Yes ○ No	Tuberculosis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Ulcers	○ Yes ○ No
Convulsions	○ Yes ○ No	Heart Trouble/Disease	○ Yes ○ No	Psychiatric Care	○ Yes ○ No	Venereal Disease	○ Yes ○ No
						Yellow Jaundice	○ Yes ○ No

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

Dr. George Wick, DDS

1234 Old Henderson Rd.
Columbus, OH 43220
(614) 268-9443

Thank you for choosing Dr. George Wick, DDS for your dental needs. Our primary mission is to deliver the best and most comprehensive 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.

Payment Options:

You can choose from:

-Cash or Check

*5% courtesy accounting adjustment to patients who pay in full for their treatment **PRIOR** to completion of care

-Visa, MasterCard, Discover or American Express

-Convenient monthly payment options from Care Credit's healthcare credit card

*No annual fees or prepayment penalties
*6 months interest free for treatment plans under $1,000
*12 months interest free for treatment plans over $1,000
*Extended low monthly payment plans are also available up to 60 months with a low interest rate of 14.9%

Please note:

Dr. George Wick requires payment prior to the completion of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For larger, more comprehensive treatment plans of $4,000 or more, a 10% deposit is required to secure your initial appointment (the deposit will go toward your treatment). **Please keep in mind we are reserving a large part of our day for you and in the event that a cancellation is made without 7 days notice your deposit will be forfeited.**

For patients with dental insurance--we are happy to work with your carrier to maximize your benefits. As a courtesy, we will estimate an out of pocket portion, but please keep in mind that all quotes are just an estimate and we cannot guarantee insurance payments. If your insurance does not pay as expected any remaining balance will be your responsibility.

We charge $50 for returned checks.

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

Name (please print) Patient, Client, Parent or Guardian Signature Date

If you would like a copy for your records, please ask a staff member.

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HIPAA PRIVACY AUTHORIZATION FORM

DATE:_____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITIED AUTHORIZATION AND RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for the healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR/FACILITIES IN THE FUTURE.**

_____ _____

Patient name(s) **(please print)** **Signature** of patient, parent or guardian

Please list any other parties who can have access to your health information (this includes step parents, grandparents and any care takers who can have access to this patient's records):

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

I authorize contact from this office to confirm my appointments, treatment & billing information via:

_ Cell phone confirmation
_ Home phone confirmation
_ Work phone confirmation
_ Text message to my cell phone
_ Email Confirmation
_ **Any of the above**

I authorize information about my health be conveyed via:

_ Cell phone confirmation
_ Home phone confirmation
_ Work phone confirmation
_ Text message to my cell phone
_ Email Confirmation
_ **Any of the above**

I approve being contacted about special services, events, fund raising efforts or new health info on behalf of this Healthcare Facility via:

_ Phone message
_ Text message
_ Email
_ **Any of the above**
_ **None of the above** (opt out)

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office use only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this acknowledgement but did not because:

It was emergency treatment ___
I could not communicate with the patient ___
The patient refused to sign ___
The patient was unable to sign because ___
Other (please describe) ___
_____

Signature of Privacy Officer_____