Your First Visit Is All About You

*******PLEASE LET US KNOW PRIOR TO YOUR APPOINTMENT, IF YOU HAVE EVER BEEN TOLD THAT YOU NEED TO PREMEDICATE (TAKE ANTIBIOTICS) FOR ANY DENTAL SERVICES *******

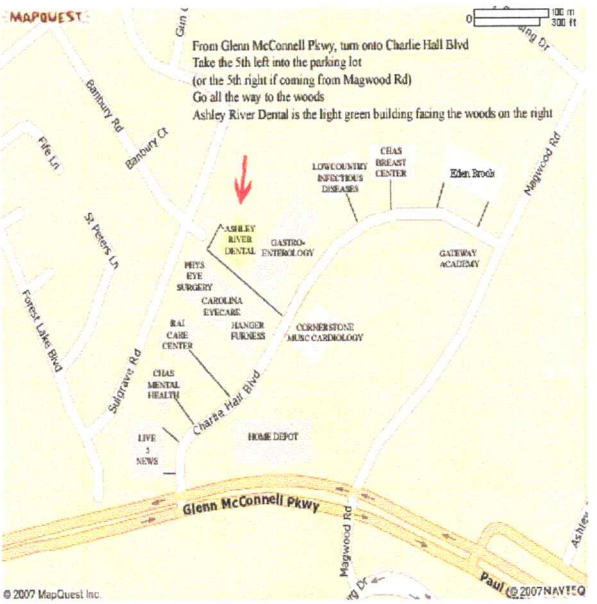
Your initial visit with Dr. Bueschgen & Dr. Turner includes:

- **Introduction to our entire team at the reserved visit**
- **A review of your medical and dental history**
- **Digital x-rays of your teeth and mouth**
- **Examination of your teeth, jaw and gums to chart existing conditions and problems**
- **An intra oral camera slide show, so you'll be an informed partner in your dental care**
- **Treatment recommendations to restore your mouth to good health**
- **Oral hygiene instruction and preventive suggestions to help you avoid future problems**
- **A discussion of financial options that can help make your care more affordable**

We make sure your first visit is informative, so we allow ample time for our doctors and staff to answer your questions and concerns.

Bring Your Smile And Things To Your First Visit

- Your completed patient forms
- Your insurances card and photo ID
- Your x-rays and records from your prior dental provider **(EMAIL 48 HOURS PRIOR TO YOUR APPOINTMENT) Email:** info@wolfdental.com



PATIENT INFORMATION (CONFIDENTIAL)

PATIENT'S NAME_____
FIRST MI LAST PREFERRED NAME

ADDRESS_____ CITY_____ STATE_____ ZIP_____
HOME PHONE_____ WORK PHONE_____ CELL PHONE_____

☐ MALE ☐ FEMALE

BIRTHDATE_____ SSN_____
EMPLOYER_____
EMPLOYERADDRESS_____ CITY_____ STATE_____ ZIP_____

IF A COLLEGE STUDENT, ☐ F.T. ☐ P.T., NAME OF SCHOOL_____ EST GRAD DATE_____
IF A MINOR, PARENT'S / GUARDIAN'S NAME _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

PERSON TO CONTACT IN CASE OF EMERGENCY_____ PHONE_____

PHARMACY:_____ PHONE:_____

RESPONSIBLE PARTY ☐ SAME AS PATIENT

NAME OF PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT_____ RELATIONSHIP TO PATIENT_____
BIRTHDATE_____ SSN_____
CELL PHONE_____ HOME PHONE_____
ADDRESS_____ CITY_____ STATE_____ ZIP_____
EMPLOYER_____ WORK PHONE_____
E-MAIL (This will be the method of contact for future reminders)_____

INSURANCE INFORMATION

INSURANCE COMPANY_____
☐ SAME AS PATIENT ☐ SAME AS RESPONSIBLE PARTY
NAME OF POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____
BIRTHDATE_____ SSN_____
EMPLOYER_____ WORK PHONE_____

DO YOU HAVE ADDITIONAL INSURANCE? ☐ YES ☐ NO

INSURANCE COMPANY_____
NAME OF POLICY HOLDER_____ RELATIONSHIP TO PATIENT_____
BIRTHDATE_____ SSN_____
EMPLOYER_____ WORK PHONE_____

SIGNATURE_____ DATE_____

AUTHORIZATION
SHARE PERSONAL INFORMATION
LEAVE PERSONAL HEALTH INFORMATION BY ALTERNATE MEANS

Patient Name:_____ **DOB:**_____

Patient Mailing Address:_____

(PLEASE CHECK ALL THAT APPLY)

____ May give dental and/or account information to the following:

_____ _____
Name **Relationship**

_____ _____
Name **Relationship**

____ May leave detailed message on voicemail at home #_____

____May leave detailed message on voicemail on cell #:_____

____ May leave detailed message with person listed above: _____

____ DO NOT LEAVE DETAILED MESSAGE ON ANY VOICEMAIL OR ANYONE OTHER THEN ME.

With my signature below, I acknowledge and understand that this information will be kept in my medical records and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify our practice should you change one or more of the names and/or telephone numbers listed above.

_____ _____
Patient or legally authorization signature **Date**

Insurance Plan Information that You Are Responsible for Understanding and Providing to our office "Prior" to all Dental Appointments

06/16/2016

Annual Maximum/.Benefit Period: Most dental plans have an annual dollar maximum. This is the maximum dollar amount a dental benefit plan will pay toward the cost of dental care within a specific benefit period (usually January through December). The patient is personally responsible for paying any costs above the annual maximum, as well as, knowing your remaining yearly dollar amount of benefits.

Categories of Coverage: Many dental plans offer three classes or categories of coverage – often with different reimbursement levels for each. Procedures within a category of services can vary from plan to plan, so be sure to read your benefits information carefully.

The three levels typically work this way:

- **Class I** procedures are diagnostic and preventive. These are usually covered at the highest percentage (for example, 100 percent of the plan's approved fee). This gives patients a financial incentive to seek early or preventive care because such care can deter dental disease and the need for more expensive treatments in the future.
- **Class II** includes basic procedures – such as fillings, extractions and periodontal treatment – that are sometimes reimbursed at a slightly lower percentage (80 percent, for example).
- **Class III** is for major services and is usually reimbursed at a lower percentage (for example, 50 percent). Class III services may have a waiting period before they are covered.

Coinsurance: Many insurance plans have a coinsurance provision. **(Estimated Only via our office)**. That means the benefit plan pays a pre-determined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the coinsurance, and it is part of your out-of-pocket cost.

Coordination of Benefits (COB). (ONLY if you have secondary dental coverage) If you are entitled to benefits from more than one group dental plan, the amounts paid by the combined plans will not exceed 100 percent of your dental expenses from your "primary" ins. This is known as coordination of benefits, or COB.

Deductibles. Most dental benefit plans have a deductible – a specific dollar amount you must pay before the plan begins to cover your expenses. During a benefit period, you personally will have to pay a portion of your dental bill before your benefit plan will contribute to your cost of dental treatment.

Limitations and Exclusions. Dental benefit plans are designed to help with part of your dental expenses; they may not always cover every dental need. The typical plan includes limitations and exclusions, meaning the plan does not cover every aspect of dental care. This can relate to the type or number of procedures, the number of visits or age limits. These limitations and exclusions are carefully detailed in the plan booklet and deserve your attention.

HIPPA: Dental practices are now unable to acquire "your" prior dental history from your insurance company due to the privacy laws for healthcare information. It is your responsibility to gather this information "prior" to your dental appointment—such as, but not limited to, x-rays, office visits, and restorative treatments.

SIGNATURE DATE

ASHLEY RIVER
Comprehensive Family Dentistry, LLC

Local Anesthetic Consent Form

We strive to make dental care as comfortable as possible. One of the strategies we employ is the use of dental anesthetics (such as lidocaine, mepivacaine, articaine). Although the use of the local anesthetics is safe, well-established procedure to control pain, adverse reactions can occur. These reactions include, but not limited to, the following items:

1. Rapid heartbeat-the anesthetic may make your heart race for a few minutes after the anesthetic is administered; it usually is short lived. If you have high blood pressure, please let Dr. Bueschgen or Dr. Turner know.

2. Fainting-can be associated with a rapid pulse, usually associated with fear.

3. Hyperventilation-this is characterized by rapid breathing, lightheadedness, tingling in the hands, and possible tightness in the chest. It is also associated with fear.

4. Allergic Reactions-these are extremely rare with the anesthetics we use. They can be characterized by swelling, redness, or anaphylactic reactions that involve trouble with breathing. If you have experienced an adverse reaction to an anesthetic before, please let us know.

5. Toxicity Reactions-these occur from overdose or rapid adsorption of the anesthetic into the blood stream. We will never administer more anesthetic that is recommended for your body size, but it is important to understand that everyone has a different tolerance to medications.

Complications that can arise from the use of a local anesthetic include:

1. Numbness to additional areas of the face can occur due to variations in nerve anatomy. These areas will start to feel normal after the anesthetic wears off, usually in 1 to 4 hours.

2. Paresthesia can occur when a nerve is traumatized during the administration of anesthetic. This may result in a lingering feelings of numbness or tingling, burning, or pain. Although rare, it most often occurs when numbing the lower back teeth. In most cases, the symptoms of paresthesia gradually diminish with time, but, in some rare cases they may be permanent. Unfortunately, the only alternative to avoid this risk is to have the dental work completed without anesthetic (most people accept the risk). If you experience symptoms of paresthesia after dental work, please inform us as soon as possible because early treatment is essential for certain cases of paresthesia.

3. A "shocking" sensation can occur when the anesthetic is administered close to the nerve, it is usually short lived.

4. Hematoma- This is characterized by blood pooling outside of the blood vessels and can have the appearance of a swollen bruise. It occurs when a blood vessel is punctured during the procedure. They may be visible for up to 2 weeks, but will usually resolve on their own.

5. Trauma to the lips & cheeks while the anesthetized tissue is numb.

6. Jaw pain can result from the muscles around the area of the anesthetic or from holding your mouth open for an extended period of time during dental work.

Please let us know if you have had any type of allergic or adverse reaction to dental anesthetics in the past. Fortunately, complications related to the use of dental anesthetics are rare.

I consent to the use of dental anesthetics whenever Dr. Bueschgen or Dr. Turner recommends it for dental treatment. I understand that I can certainly request not to use anesthetic for any procedure.

_____ _____

Patient or Guardian Signature Date

ASHLEY RIVER
Comprehensive Family Dentistry, LLC

FINANCIAL AGREEMENT

To help us provide the highest quality of care in the most efficient and reasonable manner, it is necessary for us to enforce the following practice policies:

PAYMENT OF FEES:

- If you do not have dental insurance, payment is due in full as you check out after each visit. We accept cash, check and all major credit cards. There will be a charge added for non-sufficient fund checks returned to us. We also sponsor a payment plan administered by Care Credit that allows you to start treatment today and spread payments over time. This payment option is subject to credit approval. If Care Credit declines your credit application, another form of payment listed above is required at check out. Please inquire at the desk if you are interested in Care Credit.

INSURANCE:

- Your dental insurance policy is a contract between you and your insurance company. Since all policies are unique with their own benefits and limitations, you are strongly encouraged to refer to your benefits booklet for details on your policy. *If you have any questions regarding your insurance benefits, please refer to your insurance company or employer.*
- We will file primary and secondary insurance claims for our patients provided we have the accurate and complete insurance information. We estimate that you will owe after your insurance benefits are applied and will charge you the amount at each visit. We will collect any deductible amount that has not been met at this appointment. If we have not received payment from your insurance company after 45 days from the date of the original filing, payment in full is expected from you.
- Please do not discuss the financial aspect of your care with the doctor. It is important that the doctor be allowed to practice dentistry and provide patient care. Please work with the office manager on any account questions or problems you have.

By signing below, I have acknowledged that I have read and understand the above information and I agree to abide by all policies explained above.

I hereby acknowledge that if my account is turned over to an attorney or collection agency, I will be responsible for any attorney fees, collation fees and court cost fees.

I have read the HIPPA privacy policies of the office and I understand that I may receive a copy of these policies upon request.

_____ _____

Patient/Responsible Party **Date**

ASHLEY RIVER
Comprehensive Family Dentistry, LLC

LATE AND/OR MISSED APPOINTMENT FEE POLICY

(Please Read Carefully)

- **Late Arrival**: When we reserve time for you, we require all of that time to provide you with the best quality work possible. When you are late it decreases our ability to accomplish this. If you arrive more than 10 minutes late, your appointment will be **rescheduled.**

- **Cancellation or changes** to your appointment time less than **48 hours** prior to your reserved dental appointment will be subject to a $50.00 broken appointment fee, which will be charged to your account.

- All **missed appointment fees** must be paid in full before another appointment will be scheduled.

- **By signing our Late and/or Missed Appointment Fee Policy you have agreed to pay this broken appointment fee of $50.00.**

_____ _____

Patient or Authorized Guardian Signature Date

Ashley River Family Dentistry, LLC

Eaglesoft Medical History default 2015(Copy2)

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, c

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	
Have you been told you need an antibiotic prior to dental procedure?	◯ Yes ◯ No	
Have you ever had periodontal therapy/surgery?	◯ 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

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	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	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 above? ◯ 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:_____