Welcome!

Ward Family Dentistry
PO Box 948, 507 S. Ash St., Suite 103
Buffalo, MO 65622
417-345-2101

Patient Information (Confidential) Date:_____/_____/_____ SSN:_____-_____-_____

Name:_____Date of Birth:_____/_____/_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:(_____)_____-_____Cell Phone:(_____)_____-_____Email:_____

Check appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer:_____Business Phone:(_____)_____-_____

Business Address:_____City:_____State:_____Zip Code:_____

Spouse's Name:_____Phone Number:(_____)_____-_____

Spouse's Employer:_____Business Phone:(_____)_____-_____

If Student, Name of School/College:_____Whom may we thank for referring you?_____

Person to Contact in Case of Emergency:_____Phone:(_____)_____-_____

Responsible Party (If different from patient information)

Name:_____Relationship to Patient:_____

Address:_____City:_____State:_____Zip Code:_____

Home Phone:(_____)_____-_____ Cell Phone:(_____)_____-_____ Date of Birth:_____/_____/_____

Employer:_____Business Phone:(_____)_____-_____SSN:_____-_____-_____

Insurance Information Name of Policy Holder:_____

Relationship to Patient:_____Date of Birth:_____/_____/_____ SSN:_____-_____-_____

Name of Employer:_____Business Phone:(_____)_____-_____

Address of Employer:_____City:_____State_____Zip Code:_____

Insurance Company:_____Group #:_____Policy/ID#_____

Insurance Company Address:_____City:_____State:_____Zip Code:_____

Insurance Company Phone Number:(_____)_____-_____ **Please give a copy of your insurance card to the receptionist.

Medical History

Physician:_____Office Phone:(_____)_____-_____Date of Last Exam:_____/_____/_____

Are you under medical treatment now? (If yes, explain.)_____

Have you been hospitalized for any surgeries or serious illnesses in the past five years? (If yes, explain.)_____

_____

Have you ever had a joint replacement or implant? (If yes, explain.)_____

Are you taking any medications (including non-prescription medications)? (If yes, list medications.) _____

_____

Have you ever taken bisphosphonates? (If yes, please list what type and when.)_____

Do you use controlled substances?_____Do you use tobacco?_____

Do you have a persistent cough or throat clearing not associated with a known illness (more than three weeks)? (If yes, explain.)_____

Are you allergic to or have you had any reactions to the following? (Circle if "yes".):

Local Anesthetics (e.g. Novocain) Penicillin or any other antibiotics Sulfa Drugs

Barbiturates Sedatives Iodine Aspirin Latex Rubber

Any Metals (e.g nickel, mercury, etc.) Other (please list)_____

Do you have or have you had any of the following? (Circle if "yes".):

High Blood Pressure Heart Attack Rheumatic Fever Swollen Ankles Asthma

Fainting/Seizures Low Blood Pressure Epilepsy/Convulsions Leukemia Diabetes

Kidney Diseases AIDS or HIV Infection Thyroid Problem Angina Heart Disease

Cardiac Pacemaker Heart Murmur Frequently Tired Anemia Emphysema

Cancer Arthritis Hepatitis/Jaundice Sexually Transmitted Disease Stroke

Stomach Troubles/Ulcers Chest Pain Easily Winded Hay Fever/Allergies Tuberculosis Radiation Therapy

Glaucoma Recent Weight Loss Liver Disease Heart Trouble Respiratory Problems

Mitral Valve Prolapse Other (please explain):_____

Women Only: Are you pregnant?_____ (If yes, please list due date.)_____

Are you nursing?_____Are you taking oral contraceptives?_____

Dental History Name of Previous Dentist:_____Date of last Exam:_____

Do your gums bleed while brushing or flossing?_____Are your teeth sensitive to hot or cold?_____

Are your teeth sensitive to sweet or sour?_____Do you feel any pain in any of your teeth?_____

Do you have sores or lumps in or near your mouth?_____Have you had any head, neck, or jaw injuries?_____

Circle if you have ever experienced any of the following problems in your jaw: Clicking Pain

Difficulty opening or closing Difficulty in chewing

Do you have frequent headaches?_____Do you clench or grind your teeth?_____

Do you bite your lips or cheeks frequently?_____Have you ever had difficult extractions?_____

Have you ever had prolonged bleeding after an extraction?_____

Have you had any orthodontic treatment? (braces or retainers)_____

Have you had any periodontic treatment? (deep cleanings or gum surgeries)_____

Do you wear dentures or partials?_____Have you ever received oral hygiene instructions?_____

Authorization and Release—I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination, to other healthcare practitioners involved in my treatment and also to third-party payors (insurance companies) for payment. I authorize and request my insurance company to pay directly to the dentist for services rendered. I understand that my dental insurance carrier may pay less than the actual bill for services and that any estimates of benefits are not a guarantee. I agree to be responsible for any amounts not paid by insurance. I understand that overdue bills will be subject to a finance charge. I also understand that non-payment will result in my account being turned over to a collection agency. By signing below, I am acknowledging that I may be contacted by phone (including cell phone), mail, or email in regards to appointment times, balances owed, as well as other viable reasons that pertain to my dental care or my account. I also understand that on occasion, x-rays or treatment photos may be shared on websites, social media, or with other dental professionals for educational purposes only. We will not use your name or other personal information. If you do not wish to participate, please notify us so we can give you the op-out form.

_____	_____	_____/_____/_____
(signature)	(relationship to patient)	(date)

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Acknowledgement of Receipt of Notice of Privacy Practices
Our Notice of Privacy Practices are displayed in the office, or you are welcome to request a written copy for your records.

I, _____(patient name), have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Patient or Responsible Party's Name

_____
Signature

Date:___/___/___

You may Refuse to Sign This Acknowledgement, but may be refused dental treatment by doing so.

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (circle one):

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining the acknowledgement

Other (specify):_____