Joshua M. Wilges, DDS
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JMW & ASSOCIATES

Please note that your personal identifying information is private but is necessary for billing purposes and in communicating with your insurance carrier.

Name _____ Prefer to be Called _____

Sex ❍ Male ❍ Female ❍_____ Pronoun ❍ He/Him ❍ She/Her ❍ They/Their ❍ _____

Address _____ City _____ State____ ZIP_____

E-Mail _____ Cell Phone_____

Preferred Contact Method ❍ *Cell phone* ❍ *Text Message* ❍ *E-mail*

Employer _____ Occupation _____

Social Security # _____ Date of Birth _____

Emergency Contact_____ Contact Number_____

Date of Last Dental Visit _____ Referred by _____

Is there a particular reason for your visit today? _____

Medications _____

Allergies _____

Are you allergic to Latex? ❍ *Yes* ❍ *No*

Have you ever had complications during or following dental treatment? ❍ *Yes* ❍ *No*
If yes, please explain _____

Have you ever had any adverse reactions to local anesthetic? ❍*Yes* ❍ *No*

Please circle any of the following, which may apply to your heath history:

| | | | |
|---|---|---|---|
| Anemia | Arthritis | Artificial Joints | Asthma |
| Cancer | Dizziness | Epilepsy/Seizures | Bleeding |
| Fainting | Glaucoma | HIV / AIDS | Heart Disease |
| Heart Murmur | Hepatitis | High Blood Pressure | Kidney Disease |
| Liver Disease | Nervous Disorder | Pacemaker | Rheumatic Fever |
| Radiation | Stomach Disease | Sinus problems | Stroke |

Do you have any health problems that need further clarification? _____

**WOMEN:** Are you pregnant? ❍*Yes* ❍ *No* If yes, when are you due? _____
Are you nursing? ❍*Yes* ❍ *No*

**Acknowledgement of Privacy Practices**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance & Accountability Act of 1966 (HIPAA). I understand that this information can and will be used to:

- Provide & coordinate my treatment among a number of health care providers who may be involved in that Treatment directly and indirectly.
- Obtain payment from third-party payers for my services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed that my dental provider's Notice of Privacy Practices contain a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice and Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is disclosed to carry out treatment, payment, or health care operations. I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

**Insurance and Collections**

**Payment is due at the time of service unless other arrangements are agreed upon**. In most cases, we are able to file insurance as a courtesy to our patients. At each appointment, the patient is expected to pay the full fee for service, and will receive direct reimbursement from the insurance company. Certain necessary procedures may be excluded from coverage or considered inclusive to another procedure by your insurance company, and certain frequency limitations may apply. The patient is ultimately responsible for any balance at Joshua M. Wilges DDS PC and agrees to pay for the services performed regardless of insurance acceptance, denial, or reimbursement. Please contact your insurance carrier for your benefit information as all insurance companies and plans are different.

## Cancellations and No-shows

**If you are unable to keep an appointment, kindly give our office at least 24 hours' notice to avoid a missed appointment charge of $75.**

We will make every attempt to contact you to confirm your appointment. Currently, we confirm appointments via email, text message, and phone calls in hopes that these added efforts will make your appointment confirmations easier. We ask that you please be responsible for keeping your appointment as a courtesy to our office as well as other patients.

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If any of my health information changes, I will inform the doctor at my next visit.

Signature _____ Date _____