



DENTISTRY@UNIVERSITY POINTE

Dr Barton E Fogel and Dr Stephen R Wendt
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West Chester, OH 45069
(513) 772-4000

PATIENT NAME _____ **GENDER** _____

SINGLE **MARRIED** **SEPERATED** **DIVORCED** **WIDOWED**

DATE OF BIRTH _____ **SOCIAL SECURITY #** _____

Address _____

City, State, Zip _____

Home # _____ Work # _____ Cell _____

Email address _____ May we confirm appointments via email? _____

WHO IS RESPONSIBLE FOR YOUR ACCOUNT CHARGES?

Name, Date of Birth, and Social Security Number same as above

Name _____

Date of Birth _____ Social Security # _____

DENTAL INSURANCE.

PRIMARY INSURANCE COMPANY _____

INSURED NAME _____ DOB _____

SS OR ID# _____ EMPLOYER _____

SECONDARY INSURANCE COMPANY _____

INSURED NAME _____ DOB _____

SS OR ID# _____ EMPLOYER _____

Referred by: _____

**I UNDERSTAND THAT I AM FULLY RESPONSIBLE FOR THE TOTAL PAYMENT OF
PROCEDURES PERFORMED IN THIS OFFICE INCLUDING ANY AMOUNTS WHICH ARE
NOT COVERED BY DENTAL INSURANCE THAT I MAY HAVE. I HAVE ALSO BEEN
PROVIDED WITH THE HIPAA GUIDELINES AND OFFICE POLICIES**

SIGNATURE X _____ DATE _____

**FOR YOUR WELFARE AND OUR EFFICIENCY OF DIAGNOSIS AND TREATMENT, PLEASE
FILL IN THE FOLLOWING CONFIDENTIAL FORM AS ACCURATELY AS POSSIBLE**

DENTAL HISTORY

When was your last dental check-up? _____ X-rays _____

Reason for today's visit _____

Previous Dentist _____ Phone _____

Did your previous dentist have any concerns? _____

Have you (or your child) reacted negatively to past dental visits? If yes, how?

Are you (or your child) nervous about today's visit? If yes, why? _____

Have you (or your child) had any adverse reactions to dental treatment? Please explain _____

Do you know if your water is fluoridated? (Please circle) YES NO

ORAL HYGIENE

How many times a day do you (or your child) brush your teeth? _____

Do you (or your child) floss? YES NO

Do you (or your child) use a Waterpik? YES NO

Do you (or your child) use a Power Toothbrush? YES NO

Do you (or your child) use a fluoride rinse? YES NO

Do you (or your child) use an antibacterial rinse? YES NO

Children only –

Does your child have any oral habits?

Finger/Thumb habit Pacifier Nail Biting Other _____

Please check all that apply:

Bad Breath

Trouble Eating

Bleeding/sore gums

Jaw Joint Pain/Clicking

Loose/Broken Fillings

Hot/Cold sensitivity

Oral Swelling, growths or sores

Sweet Sensitivity

PLEASE RETAIN THIS COPY FOR YOUR RECORDS

FINANCIAL POLICY

As a convenience, **Dentistry @ University Pointe** files dental claims on your behalf. We're happy to help with estimating your benefits. However, it's your responsibility to know the exact benefits of your plan and manage your coverage.

Annual deductibles and estimated co-payments are due the day of your appointment; if there is no dental insurance full amount will be due. We accept Cash/Personal Checks; Credit Cards-Visa, MasterCard, American Express, Discover; Financing Options CareCredit and Chase Health Advance.

If **Dentistry @ University Pointe** is unable to collect benefits from your insurance company after two attempts, you will be responsible for the entire account balance. Payment is due upon receipt of your statement.

Your signature on this Financial Policy for will serve as an Assignment of Benefits and authorize your insurance plan to make payments directly to **Dentistry @ University Pointe**.

CONSENT FOR CARE

You authorize **Dentistry @ University Pointe** to diagnose and perform preventive and therapeutic procedures that are necessary for your dental health.

MISSED APPOINTMENTS

Your appointment reserves our office and professional staff exclusively for you. Missed appointments increase the cost of care for all our patients. Appointments canceled with less than 24 hours notice, or missed completely, are billed directly to you at a charge of \$60 per occurrence.