



DENTISTRY@UNIVERSITY POINTE

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Welcome to Dentistry @ University Pointe. We're happy you've chosen our office for your dental care. Please take a few minutes to tell us about yourself, set up your account, and establish your new dental record.

PATIENT NAME _____

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

WHO IS RESPONSIBLE FOR YOUR ACCOUNT CHARGES?

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

Name _____

Date of Birth _____ Social Security # _____

Address _____

City, State, Zip _____

Home # _____ Work # _____ Cell _____

Email address _____ May we confirm appointments via email? _____

TELL US ABOUT YOUR PRIMARY DENTAL INSURANCE.

Policy Holder Name _____ Group Plan # _____

Policy Holder ID/SS # _____ Policy Holder's DOB _____

Relationship to You ___ Self ___ Spouse/Partner ___ Father/Mother ___ Other _____

Employer _____ Insurance Company _____

TELL US ABOUT YOUR SECONDARY DENTAL INSURANCE.

Policy Holder Name _____ Group Plan # _____

Policy Holder ID/SS # _____ Policy Holder's DOB _____

Relationship to You ___ Self ___ Spouse/Partner ___ Father/Mother ___ Other _____

Employer _____ Insurance Company _____

How did you learn of our office and who may we thank for your referral? _____

Please keep us updated on any future changes to your medications, allergies, or medical history.

When was your last dental check-up? _____

Reason for today's visit _____

MEDICAL HISTORY

General Health: Good [] Fair [] Poor []

Physicians Name _____ Last Complete Physical _____

Are you currently on any medications? Yes [] No []

If yes please list the medication and purpose: _____

Are you allergic to any medications? Yes [] No []

If yes please list: _____

Are you allergic to Latex? Yes [] No []

Please check any of the following which apply to you:

- | | |
|---|--|
| <input type="checkbox"/> Need antibiotic prior to dental work | <input type="checkbox"/> Subject to prolonged bleeding |
| <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> Excessive thirst and/or urination |
| <input type="checkbox"/> Undergone radiation therapy | <input type="checkbox"/> Subject to fainting |
| <input type="checkbox"/> Use or have used tobacco products | <input type="checkbox"/> Recently hospitalized or surgery |
| <input type="checkbox"/> (Women) Currently pregnant? How far? _____ | <input type="checkbox"/> (Women) Currently nursing? |

Please check if you are currently, or have ever been diagnosed or treated for:

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Long term Steroid Therapy |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Anemia | <input type="checkbox"/> Autoimmune Disorders |
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Jaundice or Hepatitis | <input type="checkbox"/> Congenital Heart Defects |
| <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Abnormal Blood Pressure |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Neck/Back Problems | <input type="checkbox"/> Asthma or Hay Fever |
| <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Cancer (type) _____ |
| <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Tuberculosis or Lung Disease |
| <input type="checkbox"/> Acid Reflux | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Diabetes (type) _____ |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Hives/Skin Rash | |

Is there anything that you would prefer to talk to the doctor about in private?

Do you have any other medical conditions that are not listed here? _____

FINANCIAL POLICY FOR PATIENTS WITH INSURANCE

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. Sometimes your actual coverage will be different than the amount your insurance plan may have estimated. Once your insurance company pays its share, you may still have a balance due. Payment is due upon receipt of your statement.

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**.

FINANCIAL POLICY FOR PATIENTS WITHOUT INSURANCE

Payment is due in full on the day of service.

- Cash or Check (5% courtesy discount)
- Credit card (Visa, MasterCard, American Express, Discover)
- Care Credit - Financing with a 3, 6, and 12 month no-interest plan. Applying is quick and easy. Approvals within minutes. Ask our Office Manager for an application.

CONSENT FOR CARE

Your signature below authorizes **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.

I AGREE

I've read and agree to the Financial Policies, Consent for Care, and Missed Appointment policy. I have also been provided a copy of the Notice of Privacy Practice.

PATIENT/GUARDIAN

DATE