Robert E. Weygandt, DDS

5200 Village Creek, Suite 102 Plano Texas 75093

Patient Registration

Please complete all blanks. Place N/A if question is not applicable Date _____

Patient Information

Legal name _____Preferred name _____

Home address _____Home Phone _____

City, State, Zip _____Email _____

Employer _____Work Phone _____

Occupation _____Cell Phone _____

Sex () M () F DOB _____SSN _____Married () Single () Divorced () Widowed ()

List any family members that are patients _____

How did you hear about us? _____

Notify in case of emergency _____Home Phone _____

Work Phone _____ Cell Phone _____

Primary Insurance

Person responsible for Account _____DOB _____SSN_____

Address if different from patient _____

City, State, Zip _____Relation to patient _____

Insurance Company _____Employer _____

Insurance phone _____ID # _____Group # _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorized the insurance company indicated in this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorized the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature _____ Date _____

() Patient () Parent () Legal Guardian

Payment is due at the time of treatment unless prior arrangements have been approved

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Welcome! So that we may provide you with the best possible care
Please complete this medical/dental history form. All information is completely confidential

Dental History

Patient Name _____
Medical Alert _____

What is the reason for you visit today? _____
_____
Date of your last dental visit _____**Last dental cleaning** _____**Last Full mouth x-rays**_____
What was done at your last dental visit? _____
Previous dentist name _____**Telephone** _____
Address _____**State** _____**Zip** _____
How often do you have dental examination? _____ **How often do you brush your teeth?** _____
How often do you floss? _____ **What other aids do you use? (interplak, toothpick, etc.)** _____

Do you have any dental problems now? Yes No
If Yes, please describe: _____
Are any of your teeth sensitive to:
Hot or cold? Yes No
Sweets? Yes No
Biting or Chewing? Yes No
Have you noticed any mouth odors or bad taste? Yes No
Do you frequently get cold sores, blisters or any other oral lesions? Yes No
Do you gum bleed or hurt? Yes No
Have your parents experienced gum disease Or tooth loss? Yes No
Have you noticed any loose teeth or change In your bite? Yes No
Does food tend to caught in between your teeth? Yes No
If Yes, where? _____

Are you satisfied with your teeth's appearance? Yes No

DO YOU:

Clench or grind your teeth while awake or asleep? Yes No
Bite your lips or cheeks regularly? Yes No
Hold foreign object with your teeth? Yes No
(Pencils, pipe, pins, nails, fingernails) Yes No
Mouth breath while awake or asleep? Yes No
Have tired jaws, especially in the morning? Yes No
Smoke or chew tobacco? Yes No

Have you ever had:

Orthodontic treatment? Yes No
Oral Surgery? Yes No
Periodontal Treatment Yes No
Your teeth ground or the bite adjusted Yes No
A bite plate or mouth guard? Yes No
A serious injury to the mouth or head? Yes No
If so, pls. describe, including cause _____
_____

Have you experienced:

Clinking or popping of the jaw? Yes No
Pain? (joint, ear, side of face) Yes No
Difficulty in opening the mouth? Yes No
Difficulty in chewing on either side of the mouth? Yes No
Headaches, neckaches or shoulder aches? Yes No
Sore muscles (neck, shoulder)? Yes No
Would you like to keep all your teeth all your life? Yes No
Do you feel nervous about having dental treatment? Yes No
If so, what is your biggest concern?
_____
Have you had an upsetting dental experience? Yes No
If yes, please describe _____
_____

Is there anything else about having dental treatment that you would like us to know? Yes No
If yes, please describe: _____
_____
_____

MEDICAL HISTORY

Patient Name _____
Medical Alert _____

1. **Have you been under the care of a medical doctor during the past two years?..... Yes No**
   If yes, for what? _____
   Physician's name_____Phone_____
   Address_____City_____State_____Zip_____
2. **Have you taken any medication or drugs during the past two years?..... Yes No**
3. **Are you taking any medication, drugs or pills now?..... Yes No**
   If Yes, please list the name and dosage_____
4. **Are you aware of having allergic (or adverse reaction) to any medication or substance?..... Yes No**
   If Yes, please list: _____
5. **Have you been a patient in the hospital during the past five years?..... Yes No**
6. **Indicate which of the following you have had, or have at present.**
   Circle "Yes" or "No" to each item

Heart (Surgery,Disease,Attack)	Yes No	Ulcers	Yes No	Hepatitis A (Infectious) B (serum)	Yes No
Chest Pain	Yes No	Diabetes	Yes No	Venereal Disease	Yes No
Congenital Heart Disease	Yes No	Thyroid Problems	Yes No	A.I.D.S	Yes No
Heart Murmur	Yes No	Glaucoma	Yes No	H.I.V. Positive	Yes No
High Blood Pressure	Yes No	Contact Lenses	Yes No	Cold Sores/Fever Blisters	Yes No
Mitral Valve Prolapse	Yes No	Emphysema	Yes No	Blood Transfusion	Yes No
Artificial Heart Valve	Yes No	Chronic Cough	Yes No	Hemophilia	Yes No
Heart Pacemaker	Yes No	Tuberculosis	Yes No	Sickle Cell Disease	Yes No
Rheumatic Fever	Yes No	Asthma	Yes No	Bruise Easily	Yes No
Arthritis/Rheumatism	Yes No	Hay Fever	Yes No	Liver Disease	Yes No
Cortisone Medicine	Yes No	Latex Sensitivity	Yes No	Yellow Jaundice	Yes No
Swollen Ankles	Yes No	Allergies of Hives	Yes No	Neurological Disorders	Yes No
Stroke	Yes No	Sinus Trouble	Yes No	Epilepsy or Seizures	Yes No
Diet (Special/Restricted)	Yes No	Radiation Therapy	Yes No	Fainting or Dizzy Spells	Yes No
Artificial Joints (hips, knees, etc)	Yes No	Chemotherapy	Yes No	Nervous/Anxious	Yes No
Kidney Trouble	Yes No	Cancer/Tumors	Yes No	Psychiatric/Psychological Care	Yes No
COPD	Yes No	Autoimmune Disorder	Yes No	Osteoporosis	Yes No

7. **Do you use more than two pillows to sleep? Yes No**
8. **Have you lost/gained more than 10 pounds in the past year? Yes No**
9. **Do you have or have you have any disease, condition, or problem not listed? Yes No**
   If Yes, please list: _____
10. **Women: Are you pregnant? Yes; ____months No Nursing? Yes No Taking birth control pills? Yes No**

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____Date _____

History Review

Doctor Signature _____Date _____

Robert E. Weygandt, D.D.S.
5200 Village Creek Drive, Suite 102
Plano, Texas 75093
P 972-818-0200 F 972-818-0203

Financial Policy

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful, and to the return and maintenance of your good oral health. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which we ask you to read and sign prior to any treatment.

All patients must complete our information and insurance form before seeing a doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE.

WE ACCEPT CASH, CHECKS, VISA/MASTERCARD, AMERICAN EXPRESS, DISCOVER, OR CARE CREDIT.

WE OFFER VARIOUS PAYMENT PLANS WITH PRIOR APPROVAL.

Regarding insurance, we may accept assignment of insurance benefits. This applies to your primary carrier only. We require that all deductibles, co-pays, and/or any percentage of the bill that the primary insurance carrier does not cover, be paid on the time of service. The balance is your responsibility whether your insurance company pay or not. We cannot bill your insurance company unless you provide us with sufficient information. Your insurance company is a contract between you and your insurance company. We are not a party to that contract. In the event we do accept assignment of benefits we require that you be pre-approved for a payment plan or provide a credit card authorization to bill your account for any remaining balance. If your insurance company has not paid your balance in full within 45 days, the balance will automatically be transferred to your credit card or the designated payment plan. Please be aware that if we are not a participating provider for your insurance plan, you are responsible for payment of any portion of the charges not covered by your insurance company. We can provide you with documentation to file with a secondary carrier.

Also keep in mind that some, perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under provisions or your insurance plan.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients and we charge what is reasonable and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients

Adult patients are responsible for full payment at the time of service.

Minor Patients

The adult accompanying a minor and the parents or guardian of the minor, are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless; A.) Charges have been pre-authorized to an approved credit card, or B.) Payment by time of service cash or check at the time of service has been verified.

Missed Appointments

Unless cancelled at least 24 hours in advance, there will be a charge for missed appointments. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the above and I agree to the requirements set forth in this financial policy.

X_____ _____

Signature of Patient or Responsible party **Date**

X_____ _____

Authorized person/Witness **Date**

Credit card type _____ Name on the card _____

Credit card number _____ Expiration date _____

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Plano, Tx, 75093

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- **Protected health information may be disclosed or used for treatment, payment, or healthcare operations.**
- **The practice reserves the right to change the privacy policy as allowed by law.**
- **The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.**
- **The patient has the right to revoke this consent in writing in any time and all full disclosures will then cease.**
- **The practice may condition receipt of treatment upon execution of this content.**

May we phone, email, or send a text to you to confirm appointments? YES NO
May we leave a message on your answering machine at home or on your cell phone? YES NO
May we discuss your medical condition with any member of your family? YES NO
If YES, please name the members allowed:

_____ _____

_____ _____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Insurance Information Acknowledgment

Thank you for choosing us as your dental care provider. At Plano Cosmetic Dental, we believe that you deserve the best care. That's why we always present you with the best dental solution possible to treat your personal situation. Each year we provide outstanding dental care to hundreds of patients. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know. Your dental benefits are based upon a contract made between your employer and an insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. Dental benefit plans will never pay for completion of your dental care. It is only meant to assist you.

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for service). This means that we work with literally thousands of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore, it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE. If you would like to know your exact insurance benefit, we will be happy to file a "pre-treatment authorization" with your insurance company prior to treatment. This does delay treatment but will give you the exact out of pocket figures you may require. Many people receive notification from their insurance company that dental fees are "above usual and customary." An insurance company determines their reimbursement level by surveying a geographical area, calculating the average fee, and then determines that 80% of the average fee is customary. Included in this survey are discounted dental clinics and managed care facilities, which have severely reduced dental fees that bring down the average. Any doctor in private practice will have fees that insurance companies define as "higher than usual and customary." We bill your insurance as a courtesy. If insurance does not pay within 90 days, our office reserves the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Our office does require payment in full for your portion at the time of service. We accept MasterCard, Visa, Discover, cash, and checks (for existing patients with established payment history).

If you are in need of an extended finance option, we also work with Care Credit /Capital One, who offers a six month "same as cash" or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. Just ask one of the patient services staff for an application.

Broken Appointments: A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 24-hour notice to avoid a $35/hour cancellation fee.

After Hours/Weekend Emergencies: In the event of an emergency after regular business hours a $100 emergency fee will be charged for established patients in addition to the necessary treatment fees. Patients who are not established in the practice will be charged $150 after hour emergency fee.

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make your visits here more pleasant, please don't hesitate to ask one of our staff members.

Print: _____

Sign: _____