Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

11 Wells Street • PO Box 2058 • Westerly, RI 02891-0917 • Phone 401-596-0888

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you
Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?
☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics
☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

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Financial and Collection Policy for
Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D.

The following is a summary of our financial and collection policy.

- We expect payment on the day of service from our patients without dental insurance, with Delta Dental and Blue Cross, and with any other insurance, which directs payment to the patient.

- All co-payments are expected at the time of service for those patients who have dental insurance that will pay directly to our office.

- We do periodically increase our fees to cover the rising costs of dental supplies, utilities, staff, and all other costs associated with the day-to-day operations of our office.

- If your family is involved in a divorce situation **the parent that brings their child(ren) to our office for care is the parent that is responsible for us for the <u>full amount</u> of services rendered to the child(ren)**. We will not get involved with your personal or court ordered arrangement.

- We do bill you if you miss or cancel an appointment with short notice. You may be billed up to the full fee for the services that were to be performed at that appointment. If there are three (3) missed appointments we may choose to dismiss you from our practice.

- In the event that there is a balance on your account, you are given thirty (30) days to pay the balance in full. At thirty (30) days your account will be assessed a re-billing fee of $3.00, at sixty (60) days $5.00, and from there forward $8.00 per month until the balance is paid in full. If your account reaches ninety (90) days then your account will be forwarded to a collection agency and you will be dismissed from our practice. You will be billed for any charges incurred in collecting past due fees.

- We want you to have the care that is appropriate and necessary to maintain your dental health. We may be able to assist you with financing your care depending upon your needs.

- If you should require copies of your dental records for a second opinion, or to transfer your care to another dental provider, you will be charged a $35.00 fee, per patient, for electronic processing and the secure electronic transmission of your records. If they cannot be transmitted electronically, then they will be mailed.

I, _____, have received a copy of this office's Financial and Collection Policy and agree to abide by them.

_____ _____

Signature Date

Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

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AUTHORIZATION FOR SIGNATURE ON FILE
AUTHORIZATION OF PAYMENT/RELEASE OF INFORMATION AND FINANCIAL RESPONSIBILITY

I _____, understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D. have accepted the insurance company's verification of coverage and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for the verified benefits, I agree to be responsible for all charges for dental services and materials, which I and/or my dependents have incurred and authorized in my and/or my dependents treatment. I agree that any balance not paid by my insurance company within 60 (sixty) days will be my responsibility to pay. I agree to furnish the insurance company and Drs. Woodward and Kaufman with any additional information or paperwork requested to expedite payment of my claim. To the extent permitted under applicable law, I herby authorize release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I hereby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D. I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services rendered to my dependents or me as if I had signed each benefit of future claims.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D. This "Signature on File" will be valid from this date forward. A photocopy of this document may act as an original.

_____ TODAY'S DATE

_____ SIGNATURE OF INSURED

_____ WITNESSED BY

Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

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PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder Preferred Name:
☐ Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: ____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

○ Responsible Party is also a Policy Holder for Patient ○ Primary Insurance Policy Holder ○ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: _____ State / Zip: _____ _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: ○ Male ○ Female Marital Status: ○ Married ○ Single ○ Divorced ○ Separated ○ Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: ☐ I would like to receive correspondences via e-mail.

_____ Section 2 _____ Section 3 _____

Employment Status: ○ Full Time ○ Part Time ○ Retired

Student Status: ○ Full Time ○ Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Cell Phone #: _____

Credit Card #: _____

Please confirm at : _____

Last FMX:: _____

Last PANO:: _____

Last BWX:: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: _____.00

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Request for Release of Records

I, hereby, release all dental records, including radiographs **and daily treatment notes**, from the office of Dr._____, located at
(Previous Dentist)

_____,
(Address of Previous Dentist)

to Rebecca J. Woodward. D.M.D. and/or Adam S. Kaufman, D.M.D.
I also release you from all legal responsibility or liability that may arise from this authorization.

Please send my records via email to: info@westerlydentists.com

If you cannot email my records, then please send them to:

Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.
11 Wells Street
P.O. Box 2058
Westerly, RI 02891
Phone: (401) 596-0888
Fax: (401) 596-9710

Signature _____Date_____
(Patient or Person Authorized to Consent for Patient)

Patient's Name _____
Address: _____
_____