Ascent Dental Clinic

PLEASE PRINT

Patient Name_______________________________ **Birthday** ______________________

Home_______________________________ **Cell** ______________________________

Address____

City____________________ **State**______________________ **Zip Code**___________

Social Security #______________________ **EMAIL**__________________________

Employer__________________________ **Address**____________________________

Emergency Contact/Relationship to person_________________________________

Emergency Contact Phone Number _____________________________________

PRIMARY DENTAL INSURANCE INFORMATION

Primary Insurers' Name________________________________ **Cell**________________

Name of Dental INS.____

Group #_______________________ **ID #**____________________________________

Birthday_______________________ **SS#**____________________________________

Subscribers' Employer____

SECONDARY DENTAL INSURANCE INFORMATION

Secondary Insurers' Name______________________________ **Cell**________________

Name of Dental INS.____

Group #_______________________ **ID#**_____________________________________

Birthday_______________________ **SS#**____________________________________

Subscribers' Employer____

X____________________________________ __________________________

Signature of Patient, Parent, or Guardian **Date**

NAME:________________________________ DATE:______________________

MEDICAL HISTORY

Please circle to your response to indicate if you have or have had any of the following:

PREMED? YES OR NO

Cardiovascular:

Angina (chest pain), Artificial Heart Valve, Heart conditions, Heart Surgery, High/Low Blood Pressure, Mitral Valve Prolapse

Endocrinology:

Diabetes, Hepatitis A/B/C, Jaundice, Kidney Disease, Liver Disease, Thyroid Disease

Respiratory:

Asthma, Emphysema, Respiratory problems, Sinus problems, Sleep Apnea, Tuberculosis

Musculoskeletal:

Arthritis, Artificial Joins, Jaw Joint Pain, Rheumatoid Arthritis

Hematologic/Lymphatic:

Anemia, Blood Disorders, Bruise Easily, Excessive Bleeding

Gastrointestinal:

Ulcers (Stomach), Gastrointestinal Disease, Viral Infection, AIDS, HIV Positive, HPV

Neurological:

Anxiety, Depression, Dizziness, Drug/Alcohol Addiction, Fainting, Seizures, Psychiatric Illness

MEDICAL HISTORY

Are you under the CARE OF PHYSICIAN? Physician Name____________________________

Address:________________________________Phone____________________________

Have you had a SERIOUS ILLNESS, OPERATION, OR HOSPITALIZATION IN THE PAST 5 YEARS? YES OR NO, **IF YES PLEASE EXPLAIN.**____________________________

____

PLEASE LIST ALL MEDICATIONS & OTC MEDICINE(S) OR A COPY.

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PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO.

____

HAVE YOU EVER IN THE PAST, OR CURRENTLY TAKE ANY MEDICATIOINS FOR OSTEOPENIA/OSTEOPOROSIS OR BONE DISEASE? PLEASE LIST MEDICATIONS.

____

MAJOR SURGERIES? YES/NO LIST________________________________

CONSENT: The undersigned authorizes Doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medications, and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I have read, understand and agree to the above terms and conditions.

______________________________ __________________________

Signature of Patient/Guardian **Date**

NAME____________________________ DATE________________________

Dental History

Please circle any of the following conditions that apply to you.

Periodontal (GUM) Health: Bleeding/Swollen/Irritated gums, Bad Breath, Loose/Shifting teeth, Previous Perio (Gum disease), Pain/Discomfort, Sensitivity (Hold/Cold/Sweet), Pressure, Dry Mouth

Function: Grinding/Clenching, Headaches, Jaw Joint (TMJ) pain, Jaw Clicking/Popping, Bad bite, Speech Impediment, Mouth Breathing, Sore Muscles (Neck, Shoulders), Difficulty Opening/Closing, Difficulty Chewing

Appearance: Discolored, Chipped/Broken, Worn, Misshaped, Crooked, Spaces, Overbite, Flat

Habits: Thumb sucking, Nail biting, Cheek/Lip biting, Chewing on ice/foreign objects

Sleep Pattern or Conditions: Sleep Apnea, Snoring, Daytime Drowsiness

Fear (dentist, needles, drill, etc.): Anxiety, Bad dental experiences, Noises

Social: Tobacco Y/N IF YES- How much____________________ How long________________

Alcohol Frequency____

Drugs Frequency____

Please share the following dates:

Last cleaning____

Last Oral Cancer Screening____

Last Complete X-Rays____

Name of previous Dentist____

City___________________**State**____________**Phone**____________________________

Why did you leave?____

What would you like to change about your smile?____________________________________

Ascent Dental Clinic

220 Alabama Street

Columbus, MS 39702

Welcome to our office. We appreciate the confidence you place with us to provide dental services. The best patient-doctor relationships are maintained when there is a complete understanding of the treatment rendered and the fee. Please feel free to discuss the treatment or the fee with us at any time.

Self-pay patients must pay for the services on which they are rendered. We offer several payment options to choose from:

-Cash, Check, Visa, MasterCard, Discover, American Express.

-Monthly payment options from Care Credit Healthcare Credit Card (Subject to approval)

For patients with dental insurance we are happy to file your insurance for reimbursement for your treatment. However, it is the patient's responsibility to pay deductibles, co-insurance/co-pays on the day of service, and any other balance not paid by insurance. If we are filing your claim, we will allow 45 days from the filing date for the carrier to process your claim and make payment. If an insurance payment is not received within this time frame, we will notify you to clear your account. Insurance filing is done as a courtesy to you and does not dismiss your responsibility to pay for services.

I understand that I am financially responsible for all charges incurred whether or not paid by an insurance carrier. ____________________________

(Patients Initials)

I hereby authorize said assignee all information necessary to secure payment. This assignment applies to all charges outstanding as of the date of signature and remains in effect for all current and future charges until revoked in writing. Should the account be referred to an attorney for collection the undersigned shall pay the reasonable attorney's fees and collection expense.

Patients Name____ **Date**________________________

Signature of person responsible for bill____

ASCENT DENTAL CLINIC

APPOINTMENT CANCELLATION POLICY AGREEMENT

The office of Dr. James Wiygul is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (662) 328-5197 by 12:00 PM on the day prior to your scheduled appointment to notify us of any changes or cancellations. **To cancel a Monday appointment, please call our office by 5:00PM Thursday.** If prior notification is not given, you will be marked as a "No Show" and you will be charged $75.00 for the missed appointment. This fee will not be billed to insurance and must be paid prior to your next appointment. Any further "No Show" appointments may result in the termination of the patient form the practice.

To ensure availability is managed appropriately, it is necessary for us to have this policy for missed appointments. Please sign below to consent to these terms.

______________________________________ __________________

Signature of Patient, Parent, or Guardian **Date**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

I, ______________________________________, have received a copy of this offices Notice of Privacy Practices.

____

Please Print Name

____

Signature

____

Date

AUTHORIZATION TO RELEASE INFORMATION

Purpose: This form is used to obtain authorization to release information regarding yourself covered under the Privacy Act to people other than yourself.

I, ______________________________________, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself.

______________________	______________________
Please Print Name	**Relationship**
______________________	______________________
Please Print Name	**Relationship**
______________________	______________________
Please Print Name	**Relationship**

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- o Individual refused to sign
- o Communications barriers prohibited obtaining the acknowledgment
- o An emergency situation prevented us from obtaining acknowledgment
- o Other- Please Specify

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Ascent Dental Clinic

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL/DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

OUR PRIVACY COMMITMENT- We recognize that protecting the privacy and security of your personal and confidential healthcare information is an important responsibility. This notice will tell you how we may use and share medical/dental information about you.

OUR LEGAL DUTY- Law requires us to:

- Keep your medical/dental information private.
- Provide you with a notice of our privacy practices.
- Follow the terms of our privacy notice and any update of this notice.

USE AND DISCLOSURE OF YOUR MEDICAL/DENTAL INFORMATION

We will use and disclose elements of your protected health information (PHI) in the following ways:

- FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may also share medical information about you with other health care providers to assist them in treating you.
- FOR PAYMENT: We may use and disclose your medical information for payment purposes.
- FOR HEALTH CARE OPERATIONS: Our office will use the information for business purposes such as quality improvement and to send you information.
- When release is required by law.
- In emergency situations or to avert serious health or safety situations.
- To medical examiners, coroners, or funeral directors to help them carry out their duties.
- To contact you about appointments, treatment alternatives, and other health related benefits and services.
- We may share you medical information with appropriate authorities if it is necessary to prevent serious threat to your health or safety or the health or safety of others.
- All other uses and disclosures by us will require us to obtain from you a written authorization in addition to any other permission we may have.

YOUR RIGHTS: You have the right to:

- Request that we place additional restrictions on our use or disclosure of your medical information. (We are not required to do so.)
- Look at or get copies of your medical information by signing a request form.
- Receive a list of all the disclosures by us for purposes other than treatment, payment, and healthcare operations.
- Request that we communicate with you about your medical information by different means or to different locations.
- Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons.

QUESTIONS AND COMPLAINTS- If you have questions about this notice, or if you think that we may have violated your privacy rights, please contact us.