SEAN WILSON DDS

Patient Registration

First Name: _____ Last Name: _____ Middle Initial: ___

Preferred Name: _____

Responsible Party (if someone other than patient)

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

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____Ext._____ Cellular: _____

Preferred Contact Number: □ home □ work □ cell phone

Birthdate: _____ Age:_____ Social Security: _____ Driver's Lic: _____

Patient Information Referred By: _____ (Get $100 VIP Credit for Referring!)

Address: _____

City: _____ State/Zip: _____ _____

Home Phone: _____ Work Phone: _____Ext._____ Cellular: _____

Sex: □ Male □ Female Marital Status: □ Married □ Single □ Divorced □ Separated

Birthdate: _____ Age:_____ Social Security: _____ Driver's Lic: _____

E-mail: _____ □ I would like to receive correspondence via E-mail
(Receive Birthday discounts via E-Mail!)
Emergency Contact: _____ Phone:_____ Pharmacy: _____

Section 2 Employment

Employer: _____ Position: _____

Employer Contact Info:_____

Employment Status: □ Full-Time □ Part-time □ Retired

Student Status: □ Full-Time □ Part-time

Section 3 Prior Dental Care

Last Dental exam/cleaning: _____

Previous Dentist: _____

Phone: _____

□ OK to Contact for records

Primary Insurance Information □ I also have Secondary Coverage

Name of Insured: _____ Relationship to Insured: □ Self □ Spouse □ Child

Insured Soc. Sec.:_____ Insured Birthdate: _____

Coverage offered by: □ Employer □ Self

Employer: _____ Insurance Company:_____

Address: _____ Address: _____

City, State, Zip: _____ Phone number: _____

SEAN S. WILSON DDS COSMETIC, RESTORATIVE, AND IMPLANT DENTISTRY
98 MONTGOMERY DRIVE, SANTA ROSA, CA 95404 707-578-7424

SEAN WILSON DDS

MEDICAL HISTORY Patient Name: _____ Birthdate:_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is 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 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 if yes, please explain _____ _____

Have you ever taken Fosamax, Boniva, Actonel, or any medications containing bisphosphonates? ◯ YES ◯ NO if yes, please explain _____

Are you on a special diet? ◯ YES ◯ NO Do you use tobacco? ◯ YES ◯ NO Do you use controlled substances? ◯ YES ◯ NO

Allergies

Are you allergic to any of the following? ◯ Aspirin ◯ Penicillin ◯ Codeine ◯ Local Anesthetics ◯ Acrylic ◯ Metal ◯ Latex ◯ Sulfa Drugs
◯ Other if yes, please explain_____

Women

Women: Are you Pregnant/trying to get pregnant? ◯ YES ◯ NO Taking Oral Contraceptives? ◯ YES ◯ NO Nursing? ◯ YES ◯ NO

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

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

□ Snoring Do you have a Snore Guard? □ Yes □ No Have you ever had a serious illness not listed □ No □ Yes

Do you require premedication? □ Yes □ No Are you able to take Ibuprofen/Advil? □ Yes □ No
Do you experience Anxiety while at the Dentist? □ Yes □ No Have you ever been sedated at the Dentist? □ Yes □ No

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 Sean Wilson, DDS of any changes in my medical status.

Signature of Patient, Parent, or Guardian: _____ Date: _____

SEAN WILSON DDS

We Want to Take Care of Your Concerns and Needs First….

What are your present dental concerns?

_____

_____

Do you avoid brushing any part of your mouth?	□ Yes	□ No
Do your gums bleed when brushing?	□ Yes	□ No
Are your teeth sensitive to sweet, hot/cold, or biting pressure?	□ Yes	□ No
I want to know about longer lasting solutions that may cost more.	□ Yes	□ No
Are you dissatisfied with your teeth and their appearance?	□ Yes	□ No

Does dental treatment make you nervous?
□ No □ Slightly □ Moderately □ Very

I think my dental health is…
□ Excellent □ Good □ Fair □ Poor

If I could change my smile I would make my teeth…
□ Whiter □ Straighter □ Close Spaces □ Repair Chips

Any other concerns/needs of mine are:

_____

_____

The last time I saw a Dentist and had a Hygiene exam was:

_____

_____

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SEAN WILSON DDS

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your medical information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include teeth cleaning services.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** would include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders, such as voicemail messages, text messages, postcards, letters, or emails, or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

- The right to inspect and copy your protected health information.

- The right to amend your protected health information.

- The right to receive an accounting of disclosures of your protected health information.

- The right to obtain a paper copy of this notice from us upon request

SEAN WILSON DDS

Acknowledgement of Receipt of Notice of Privacy Practice

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Sean Wilson, DDS. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health care information that might occur in my treatment, payment of services, or in the performance of the office's health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Notice of Privacy Practices is also posted in the facility.

Sean Wilson, DDS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Notice of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Notice of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY **YES** **NO**

SPOUSE ONLY **YES** **NO**

OTHER (please specify) _____ **YES** **NO**

Dental Materials Fact Sheet

I have been given the opportunity to review/receive a copy of the Dental Materials Facts as required by law.

Name of Patient or Personal Representative: _____ Date: _____

Signature of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____

SEAN WILSON DDS

Financial Policy

Thank You for choosing Sean Wilson, DDS. Our primary mission is to deliver the best and most comprehensive dental care available. Our fees are based on the quality of the materials we use and our experience in performing your needed treatment. We strive to maximize your insurance benefits and make any remaining balance easily affordable. To facilitate our mission we offer the following payment options.

Payment Options:
You can choose from:

- Cash or Check are always welcome
- Visa, Mastercard, Discover, American Express are accepted in our office.
- We also offer NO INTEREST[1] Payment Plans[2] from CareCredit
  - → Choose from 2 options:
    - Breaks your bill into a monthly payment. Dr. Sean Wilson pays your interest for 12 months. Ideal if you are able to pay your balance by 12 months.
    - Even lower monthly payments by accepting an interest transaction. Available in 24, 36, and 48 month payment plans.
  - → Applying is easy and confidential. Grab our iPad to apply.

The results are completely confidential to you and will never be discussed unless you choose to do so.

Please note:

Sean Wilson, DDS requires payment at time of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

For patients with Dental Insurance:
We are happy to work with your insurance carrier to maximize your benefit, and, as a courtesy, we will bill your dental insurance carrier. The patient is responsible for insurance claims not paid within 30 days of service.

Balances over 30 days are subject to 1.5% per month (18%) per annum finance charge, unless prior written arrangements have been made.

If you are more than 15 minutes late for your Hygiene appointment, we will have to cancel your appointment, as this does not allow enough time to clean your teeth and sets the next patient's appointment behind.

A fee of $75 is charged for patients who miss or cancel more than one time in a calendar year without a 48-hour notice.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want or need.

_____

Patient, Parent, or Guardian Signature Date

_____

Patient Name (Please Print)

[1]If paid within the promotional period. Otherwise, interest assessed from purchase date. Minimum monthly payment required

[2]Subject to Credit Approval