Nyffeler's
East Troy Family Dental

WELCOME

We appreciate your confidence in allowing us to care for your necessary dental needs. Our goal is to provide you with the highest quality of oral health in a safe and relaxed environment. We are devoted to providing you with exceptional care and making you and your family's visits educational and rewarding.

During your first visit, the dentist will review your medical and dental history with you, including:

- Sufficient x-rays to complete your dental exam
- A comprehensive periodontal (gum) evaluation
- Evaluation for tooth decay – visual exam, intraoral camera, DIAGNOdent
- Soft tissue examination of the lips, tongue and oral cavity
- Orthodontic screening evaluation – We Do Braces Here!

We have included useful forms that you can fill out ahead of time:

- Health History
- Patient Registration and Financial Responsibility

Your scheduled appointment time has been reserved specifically for you. We are aware that unforeseen events sometimes occur and result in missing an appointment. To avoid a no-show fee, we request a 48-hour notice if you need to cancel.

Please bring the enclosed forms as well as your insurance card to your scheduled appointment.

Feel free to call us at (262) 642-5695 or email us at office@easttroydental.com with any questions or for additional assistance. We are happy to be of service to you!

Thank you for choosing us to provide your dental service!

2481 Executive Drive • P.O. Box 642 • East Troy, Wisconsin 53120
Phone: 262.642.5695 • Fax: 262.642.5395
General: office@easttroydental.com • Appointments: appts@easttroydental.com

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Patient's Name: _____ D.O.B: _____/_____/_____

Address: _____

City: _____ State: _____ Zip: _____

Please Circle One: Home | Cell | Work Phone #: (_____)_____

Please Circle One: Home | Cell | Work Phone #: (_____)_____

Please Circle One: Home | Cell | Work Phone #: (_____)_____

Email Address: _____

Marital Status: _____ Drivers License #: _____

S.S. No: _____-_____-_____ Employer: _____

Method of Payment: (please circle one): Cash | Check | VISA/MC | Insurance

Who Carries Insurance: (please circle one): Self | Spouse | Parent | N/A

Dental Insurance Carrier: _____ ID #: _____

Group #: _____ If Patient is under the age of 18, name of individual who is financially responsible for Patient: _____

Spouse's Name: _____ D.O.B: _____/_____/_____

Spouse's Employer: _____ S.S. No: _____-_____-_____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of patient's appointment. If this information changes, it is the patient's responsibility to update East Troy Family Dental at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to East Troy Family Dental. We do accept payments from the dental insurance companies; however, we are not contracted with them. It is a contract between you, your employer and the insurance company.

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If requested, we will provide you with a verbal ESTIMATE of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly estimates and are not a guarantee that your insurance company will reimburse us/you according to these estimates. Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arises with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of service becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the amount is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. **Any attorney or collection fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court costs and fees.** Any personal check returned unpaid or with non-sufficient funds (NSF) will incur a $15 NSF check fee and may also subject you to court costs and attorney fees.

A cancellation fee may be charged if a 48-hour notice is not given.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

_____ Date: _____/_____/_____

Signature

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MEDICAL HISTORY FORM

Patient Name: _____ D.O.B. _____

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?	O Yes	O No	If Yes
Have you ever been hospitalized or had a major operation?	O Yes	O No	If Yes
Have you ever had a serious head or neck injury?	O Yes	O No	If Yes
Are you taking any medications, pills, or drugs?	O Yes	O No	If Yes
Do you take, or have you taken, Phen-Fen or Redux?	O Yes	O No	If Yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	O Yes	O No	If Yes
Are you on a special diet?	O Yes	O No	If Yes
Do you use tobacco?	O Yes	O No	If Yes

Women: Are you…. O Pregnant / Trying to get pregnant O Nursing O Taking oral contraceptives

Are you allergic to any of the following? O Aspirin O Penicillin O Codeine

O Acrylic O Metal O Latex O Sulfa Drugs O Local Anesthetics

Do you use controlled substances?

O No O Yes If Yes

O Other Please explain:

AIDS / HIV Positive	O Yes	O No	Cortisone Medicine	O Yes	O No	Hemophilia	O Yes	O No	Radiation Treatments	O Yes	O No
Alzheimer's Disease	O Yes	O No	Diabetes	O Yes	O No	Hepatitis A	O Yes	O No	Recent Weight Loss	O Yes	O No
Anaphylaxis	O Yes	O No	Drug Addiction	O Yes	O No	Hepatitis B or C	O Yes	O No	Renal Dialysis	O Yes	O No
Anemia	O Yes	O No	Easily Winded	O Yes	O No	Herpes	O Yes	O No	Rheumatic Fever	O Yes	O No
Angina	O Yes	O No	Emphysema	O Yes	O No	High Blood Pressure	O Yes	O No	Rheumatism	O Yes	O No
Arthritis/Gout	O Yes	O No	Epilepsy or Seizures	O Yes	O No	High Cholesterol	O Yes	O No	Scarlet Fever	O Yes	O No
Artificial Heart Valve	O Yes	O No	Excessive Bleeding	O Yes	O No	Hives or Rash	O Yes	O No	Shingles	O Yes	O No
Artificial Joint	O Yes	O No	Excessive Thirst	O Yes	O No	Hypoglycemia	O Yes	O No	Sickle Cell Disease	O Yes	O No
Asthma	O Yes	O No	Fainting Spells/Dizziness	O Yes	O No	Irregular Heartbeat	O Yes	O No	Sinus Trouble	O Yes	O No
Blood Disease	O Yes	O No	Frequent Cough	O Yes	O No	Kidney Problems	O Yes	O No	Spina Bifida	O Yes	O No
Blood Transfusion	O Yes	O No	Frequent Diarrhea	O Yes	O No	Leukemia	O Yes	O No	Stomach/Intestinal Disease	O Yes	O No
Breathing Problems	O Yes	O No	Frequent Headaches	O Yes	O No	Liver Disease	O Yes	O No	Stroke	O Yes	O No
Bruise Easily	O Yes	O No	Genital Herpes	O Yes	O No	Low Blood Pressure	O Yes	O No	Swelling of Limbs	O Yes	O No
Cancer	O Yes	O No	Glaucoma	O Yes	O No	Lung Disease	O Yes	O No	Thyroid Disease	O Yes	O No
Chemotherapy	O Yes	O No	Hay Fever	O Yes	O No	Mitral Valve Prolapse	O Yes	O No	Tonsillitis	O Yes	O No

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MEDICAL HISTORY FORM

Chest Pains	O Yes	O No	Heart Attack / Failure	O Yes	O No	Osteoporosis	O Yes	O No	Tuberculosis	O Yes	O No
Cold Sores/Blisters	O Yes	O No	Heart Murmur	O Yes	O No	Pain in Jaw Joints	O Yes	O No	Tumors or Growths	O Yes	O No
Congenital Heart Disorder	O Yes	O No	Heart Pacemaker	O Yes	O No	Parathyroid Disease	O Yes	O No	Ulcers	O Yes	O No
Convulsions	O Yes	O No	Heart Trouble / Disease	O Yes	O No	Psychiatric Care	O Yes	O No	Venereal Disease	O Yes	O No
Yellow Jaundice	O Yes	O No									

Have you ever had any serious illness that's not listed above? O Yes O No

If Yes

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:

X

Date: