WATERLOO
Dental Associates

Patient Name: _____ Birth Date: _____

MEDICAL HISTORY

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 medications that you may be taking, could have an important connection 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 heart valve replacement? ☐ **YES** ☐ **NO** **If yes, please explain:**
Have you ever had joint replacement? ☐ **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** **Please list or give list so we may make a copy.:**
Are you/Have you ever taken Fosamax, Boniva, Actonel, Alendronate or any other medications containing bisphosphonates? ☐ **YES** ☐ **NO** **If yes, please explain:**
Are you currently taking any blood thinners (ie: Coumadin/Warfarin, Plavix, Pradaxa, Eliquis or Xarelto)? ☐ **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** **If yes, please explain:**
Women are you: Pregnant/Trying to get pregnant? ☐ **YES** ☐ **NO** Nursing? ☐ **YES** ☐ **NO** Taking oral contraceptives? ☐ **YES** ☐ **NO**
Are you allergic to any of the following? ☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics ☐ Other **if yes, please explain:**

Please complete other side

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

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

Have you ever had any serious condition not listed above? ☐ **YES** ☐ **NO** **If yes, please explain:**

_____

_____

_____

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.

_____ _____

PRINTED NAME OF PATIENT, PARENT OR GUARDIAN DATE

_____ _____

SIGNATURE OF PATIENT, PARENT OR GUARDIAN DATE

WATERLOO
Dental Associates

Patient Name: _____ Birth Date: _____

DENTAL HISTORY

We take great pride in getting to know our patients and we want to customize your experience to meet your goals and expectations. To do that, we have some questions about your goals and past dental experiences. Please answer the following to the best of your knowledge.

What is the approximate date of your last dental exam?_____

Have your past dental experiences been positive or negative? Please explain.

_____

_____

Have you ever had braces (orthodontics)? If yes, do you wear retainers?_____

Have you ever been told you have gum (periodontal) disease?_____

Do you ever experience jaw pain (TMJ pain)? Do you ever wake up with a sore jaw? If yes, please explain.

_____

_____

Are you aware of clenching/grinding of your teeth at night or during the day? Have you noticed any chipping of your teeth? Do you wear an orthotic appliance (nightguard)? Please explain.

_____

_____

Do you have acid reflux? Is it being treated?_____

On a scale of 1-10 how would you rate the health of your teeth or smile?

_____

_____

If not a 10, what would you change about your teeth or smile? Please list anything else to make a 10.

☐ Whiter ☐ Longer ☐ More Even ☐ Less Worn

☐ Straighter ☐ Shorter ☐ Close Spaces ☐ More Youthful

_____

_____

_____

If treatment were necessary, would any of these be a possible concern?

☐ Fear ☐ Time ☐ Budget ☐ Other _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge that I have received the Waterloo Dental Associates' Notice of Privacy Practices.

_____

Name

_____

Signature

_____

Date

This acknowledgement page should be retained in patient's record. If acknowledgment could not be obtained from patient, the reasons must be documented below.

WATERLOO
Dental Associates

In our office, we do not want finances to prevent patients from receiving the care they need and desire. A part of your comfort and satisfaction with our office is your ability to choose the payment options best suited to your personal situation. As a courtesy to you, we will submit insurance claims on your behalf to help you receive your maximum allowable benefits. In return we ask that the patient portion be paid at the time of service.

For your convenience we offer the following payment options.

1) Cash/Check payment

2) Visa/MasterCard/Discover

3) Care Credit- An outside finance company offering interest free options and low monthly payments based on the dollar amount requested. Apply online at www.carecredit.com.

4) Waterloo Dental Associates SmileRewards Program - an in office discount plan for non-insured patients. Visit our website www.waterloodentalassociates.com or call our office to learn more.

REGARDING APPOINTMENTS, PAYMENTS, AND INSURANCE

- Changes to appointments require 24 hours notice to avoid a missed appointment fee.
- We are happy to submit a claim to your insurance company on your behalf.
- Patient balances and co-payments are due the day of your visit.
- There is a 2% charge on balances not paid by insurance within 90 days and are the account holder's responsibility.
- **We value you as our patient and understand finances influence treatment decisions. Please don't hesitate to contact us if you would like to discuss your treatment and financial options in person.**

Print Name: _____ Date: _____

Signature: _____ Date: _____

2102 Kimball Avenue • Waterloo, IA 50702 • T: (319) 233-3506 • F: (319) 233-1335
www.waterloodentalassociates.com

HIPAA INFORMATION AND CONSENT FORM

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. (www.hhs.gov).

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically include the sharing of information with other healthcare providers, laboratories, and health insurance payers as necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information, which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone e-mail, text, U.S. Mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentially rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents, which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Print name of patient/representative: _____ Date: _____

Signature of patient/representative: _____ Date: _____

_____ Patient unable or refused to sign acknowledgment

I hereby consent & authorize Waterloo Dental Associates to take photographs and use these photographs for laboratory communication, educational, marketing, and promotional purposes.

Print name of patient/representative: _____ Date: _____

Signature of patient/representative: _____ Date: _____

WATERLOO
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Patient Information (Confidential)

Name _____ Date _____
SS# _____ Birth Date _____
Address _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Work _____
Email Address _____

Check appropriate box ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Whom may we thank for referring you to our office? _____
Person to contact in case of Emergency _____ Phone _____

Employment Information

Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
If Student, Name of School / College _____ City _____ State _____ ☐ Full Time ☐ Part Time

Spouse or Parent Information

Name _____ Employer _____
Address _____ City _____ State _____ Zip _____
Phone _____ Work Phone _____ DOB _____ SS# _____

Responsible Party

Name of Person Responsible for Account _____ Relationship to Patient _____
Address if different than above _____ City _____ State _____ Zip _____
Home Phone _____ Cell _____ Birth Date _____
SS# _____ Driver's License # _____
Employer _____ Work Phone _____
Is this person currently a patient in our office? ☐ Yes ☐ No

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____
Birth Date _____ SS# _____
Name of Employer _____ Work Phone _____
Employer Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Policy/ID# _____
Ins Co. Address _____ City _____ State _____ Zip _____

Assignment and Release of Benefits

I certify this information is true and correct to the best of my knowledge. Waterloo Dental Associates has my authorization to adhere to my consents outlined on this form. I understand that I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release medical information to secure payment.

SIGNED: _____ DATE: _____

WATERLOO
Dental Associates

Greetings!

Welcome to Waterloo Dental Associates. We are pleased you have chosen us for your dental health care.

As a new patient, we realize you may have questions regarding our specific dental practice, office policies, insurance, and fee structure, so feel free to browse our website or ask if you have any questions. We believe quality care should be made available to everyone.

Preventive dentistry is our goal for every patient. This involves daily dental hygiene, proper nutrition, periodic cleanings and check-ups. It may not be where we start with every new patient, but that is what we want to attain and maintain.

Please remember to bring your New Patient Registration Information (included with this packet), dental insurance information, and your most current dental x-rays to your visit or email them to us at waterlooda@gmail.com. We need current x-rays to complete your exam; therefore if x-rays are not available, we'll need to take new ones.

Also, if you need to PRE-MEDICATE for health reasons prior to dental work, please let us know in advance of your appointment. Thank you.

Our office is located at 2102 Kimball Avenue, Waterloo, IA 50702.

We strive to develop long-lasting, trusting relationships with all of our patients, as they are our most important assets to our practice.

We're looking forward to meeting you soon!

Sincerely,

Waterloo Dental Associates

Appointment date/time:_____

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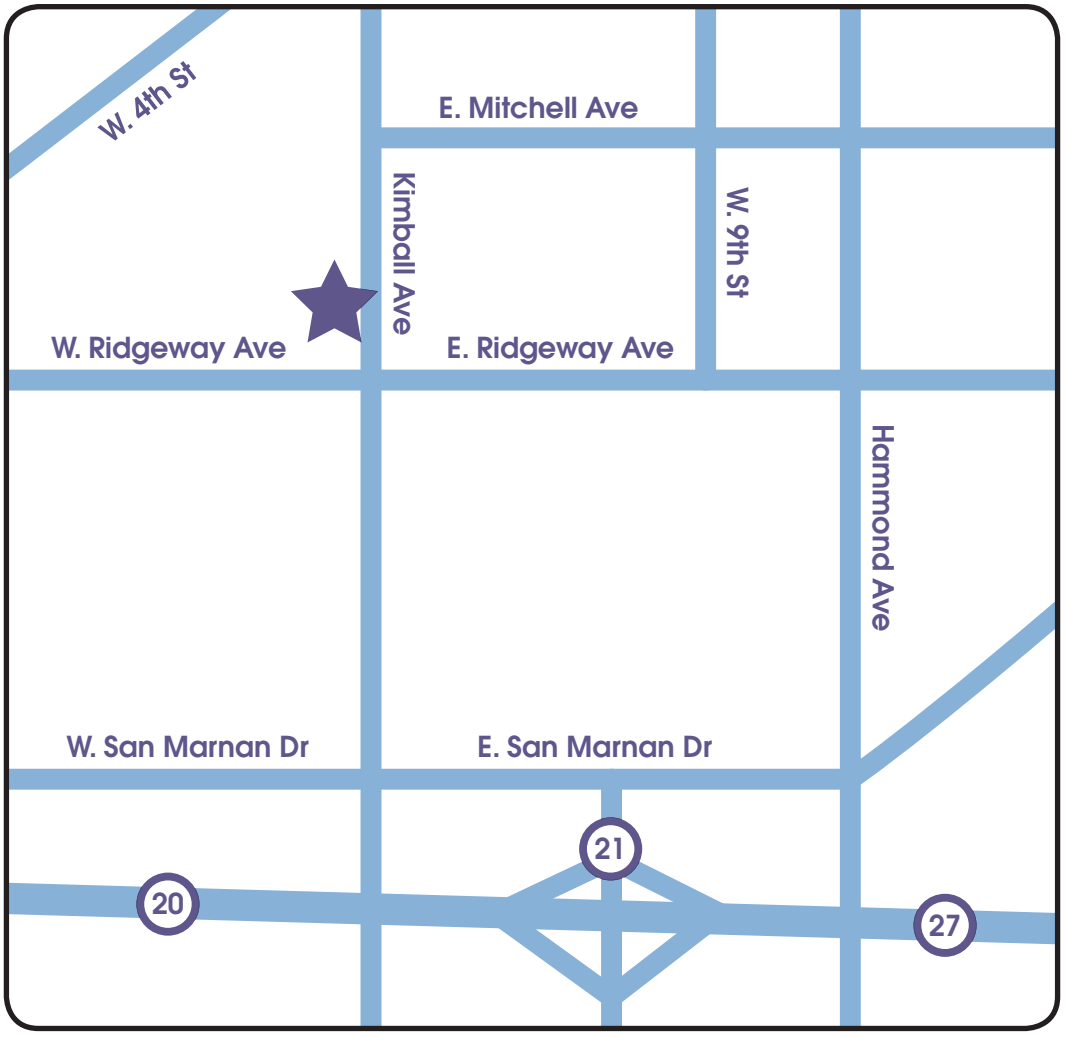

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