WE AT DR. WILCOX'S OFFICE ARE PROUD TO BE A PART OF A TEAM WHO'S PRIMARY MISSION IS TO DELIVER THE FINEST AND MOST COMPREHENSIVE DENTAL CARE TODAY. IN ORDER TO ASSIST YOU WITH YOUR HEALTH CARE INVESTMENT, WE ARE PROVIDING THE FOLLOWING PAYMENT OPTIONS.

INSURANCE

We gladly process your insurance claim: estimate your deductible and the portion not covered by your insurance . The estimated amount not covered by your insurance is due at the time of treatment. You may pay by one of the options listed below. Our estimates are subject to final approval by your insurance company; therefore, the amount due our office is subject to change. Any unpaid balances past 90 days will be charge finance charges of 18% annually. If the account becomes delinquent, patient agrees to pay collection cost and legal fees.

INITIAL PAYMENTS

Our office requires a deposit of on half at the start of treatment and payment in full once treatment is completed. A down payment is not required with the Care Credit or Citi Health monthly payment plan.

PAYMENT OPTIONS

1. CASH - Includes personal checks and money orders.

2. CARE CREDIT OR CITI HEALTH CARD - Offers a separate line of credit to cover your entire Family's health care needs.

*** A credit line can be established and approval usually taking less than 10 minutes.

*** CARE CREDIT OR CITI HEALTH CARD has an interest free option.

*** There is no annual or membership fee.

We would be happy to work with you to plan the most appropriate arrangements for your budget.

PATIENT INFORMATION FORM

NAME _____

HOME#_____WORK#_____CELL #_____

E-MAIL ADDRESS _____

HOME ADDRESS_____CITY/STATE_____ ZIP_____

SOCIAL SECURITY # _____-_____-_____ DATE OF BIRTH _____-_____-_____

MARITAL STATUS_____ PLACE OF EMPLOYMENT _____

DRIVER'S LICENSE # _____ STATE _____

SPOUSE'S NAME_____PLACE OF EMPLOYMENT_____

DENTAL INSURANCE COMPANY _____GROUP #_____

IS THE INSURED YOU OR YOUR SPOUSE? (please circle one) IF NOT YOU, PLEASE GIVE THE INSURED'S SOCIAL SECURITY # _____-_____-_____ DOB _____

PHYSICIAN_____ PHONE # _____

NEAREST RELATIVE NOT LIVING WITH YOU _____PHONE #_____

WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____

WHO IS FINANCIALLY RESPONSIBLE FOR THIS BILL? _____

I WILL BE PAYING BY: Check Credit Card Debit Card Care Credit Card Citi Health Card

I UNDERSTAND AND AGREE THAT, (REGARDLESS OF MY INSURANCE STATUS), I AM ULTIMATELY RESPONSIBLE FOR THE BALANCE ON MY ACCOUNT FOR ANY SERVICES RENDERED. I HAVE READ ALL THE INFORMATION ON THIS SHEET AND HAVE COMPLETED THE ABOVE ANSWERS. I CERTIFY THIS INFORAMTION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE. I WILL NOTIFY YOU OF ANY CHANGES IN MY HEALTH STATUS OR THE ABOVE INFORMATION.

SIGNATURE:_____ DATE:_____

PARENT (IF MINOR): _____ DATE:_____

HEALTH QUESTIONAIRE

Name _____ Birth Date _____ Today'sDate:_____

DENTAL

WHAT IS THE REASON FOR YOUR VISIT TODAY?

_____

_____

_____

1. Are you having any discomfort at this time? Yes No
2. Does dental treatment make you nervous? Yes No
3. Date of Last Dental Visit _____
4. How often do you brush? _____ Brush is: Soft Medium Hard
5. Have you ever been treated for Periodontal Disease? Yes No If so when? _____
6. Do you have any of the following?

MOUTH

Bleeding, sore gums.....Yes No

Bad Breath.....Yes No

Swelling/Lumps in Mouth.....Yes No

Biting Cheeks/Lips.....Yes No

Clicking/Popping Jaw.....Yes No

TEETH

Loose teeth.....Yes No

Sensitive to hot.....Yes No

Sensitive to sweet.....Yes No

Food Impaction.....Yes No

Clenching/Grinding.....Yes No

MEDICAL

1. Name of Your Physician _____
2. Has there been any change in your general health within the past year? _____
3. Have you had any serious illness with the past 5 years? _____ If yes, list illness _____
4. Do you have any of the following disease or problems?

Rheumatic Heart Disease.....Yes No Congenital Heart Disease.....Yes No Endocarditis.....Yes No

Cardiovascular Disease.....(CIRCLE WHAT APPLIES) Coronary Insufficiency Coronary Occlusion

Arteriosclerosis Heart Attack.....Yes No Date_____ Within last 6 months Yes No

High / Low Blood Pressure

DO YOU REQUIRE PREMEDICATION PRIOR TO DENTAL TREATMENT? Yes No

Artificial or Replacement Heart Valves.....Yes No

Pacemaker..... ..... Yes No

Stroke.....Yes No

Diabetes Type 1 or Type 2....Yes No

Hepatitis A B C .....Yes No

Liver Disease / Jaundice.....Yes No

Heart Murmur with Regurgitaton..... Yes No

Mitral Valve Prolapse .....Yes No

Artificial or Replacement Joints (Knee Hip Shoulder).....Yes No

Do you pre medicate prior to dental treatment.....Yes No

Kidney Trouble ..... Yes No COPD.....Yes No Asthma.....Yes No Tuberculosis....Yes No

Immune System Disorder (AIDS HIV Positive ARC).....Yes No Herpes Yes No

Autoimmune Disease..... Yes No

Cancer Therapy..... Yes No Type of Cancer _____ Are you in treatment now? Yes No

DO YOU TAKE ANY OF THE FOLLOWING? PLEASE CIRCLE Anti Anxiety Medication Anti Depressant Medication

Insulin for Diabetes Daily Aspirin Regiment 81 mg 325 mg

Sedatives or Tranquilizers Birth Control

Blood Pressure Medication.....Yes No

BLOOD THINNERS.....Coumadin Heparin Warfarin Pradaxa Fish Oil Vitamin E

BONE DENSITY MEDICATION? Fosamax Actenol Boniva How Long? _____

DO YOU HAVE A LATEX ALLERGY?.....Yes No

DO YOU HAVE ANY ALLERGIES TO MEDICATION? PLEASE LIST ALLERGIES....

_____

_____

_____

PLEASE LIST ALL OF YOUR MEDICATIONS AND THE NAME OF THE PRESCRIBING DOCTOR

_____

_____

_____

PHARMACY NAME AND PHONE # .....

_____

DO YOU HAVE ANY OTHER HEALTH CONCERNS THAT YOU SHOULD BRING TO OUR ATTENTION?_____

_____

TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO INFORM MY DOCTOR IF I, OR MY MINOR CHILD, EVER HAVE A CHANGE IN HEALTH.

SIGNATURE OF PATIENT, PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE

_____ DATE: _____

Update and Initials _____ DATE:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. (Available upon request) (Framed in the Reception area for all to see). You may refuse to sign this acknowledgement, if you wish.

****

I acknowledge that I have been informed of this office's Notice of Privacy Practices.

Please print your name here: _____

Signature: _____

Date:_____

******* **FOR OFFICE USE ONLY** *******

We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient, but it could not be obtained because:

_____ The patient refused to sign.

_____ Due to an emergency situation it was not possible to obtain an acknowledgement.

_____ We weren't able to communicate with the patient.

_____ Other (Please provide specific details)

_____

_____

_____

Employee signature: _____ Date:_____

HIPAA Acknowledgement of Receipt of the Notice of Privacy Practices. This form does not constitute legal advice and covers only federal, not state, law.

RICHARD W. WILCOX, DDS, MS
5306 CORTEZ ROAD WEST STE. 1
BRADENTON, FLORIDA 34210
(941)792-1440

FINANCIAL AGREEMENT

_____ I authorize use of this form on all my insurance submissions.

_____ I authorize release of information to all my insurance carriers.

_____ I understand that I am responsible for my bill.

_____ I authorize my doctor to act as my agent in helping me obtain payment from my insurance payment directly to my doctor.

_____ I authorize payment directly to my doctor.

I am aware and have been advised that I am fully responsible for any balance on my account.

Guarantor Name: _____

Guarantor Signature: _____

Patient Name: _____

Date: _____