DENTAL HEALTH CENTER

Dr. John Tessendorf & Dr. Thomas Tessendorf
215 5th Avenue Eau Claire, WI 54703
715-832-3100

PATIENT INFORMATION

Name_____Address_____
Last First Mid Int. Number and Street

_____
City Zip Code Home Phone Cell Phone

Birth date_____ Sex M F Employer_____ Bus Ph#_____

Social Security_____ Marital Status_____ Name of Spouse_____

Email Address_____ If student, name of school/college_____

Emergency Contact_____Phone_____

Which way do you prefer to have your appointments confirmed? (You may choose more than one)

_____Home _____Work _____Cell Phone _____Text _____Email

Who may we thank for referring you to our practice?
_____Insurance _____Yellow Pages _____Internet _____Other (below)

Name of person, office, or other source referring you to our practice:_____

RESPONSIBLE PARTY INFORMATION

Name_____Address_____
Last First Mid Int. Number and Street

_____
City Zip Code Home Phone Cell Phone

Birth date_____ Sex M F Employer_____ Bus Ph#_____

Social Security_____ Drivers License #_____ Financial Institution _____

Relationship to Patient _____

For your convenience, we offer the following methods of payment. Please check the option you prefer for payment in full (or patient portion/co-pay if there is insurance) at each appointment:

_____ Cash _____Check _____ Credit Card _____ I wish to discuss payment arrangements

DENTAL INFORMATION

Sensitivity to heat/cold	Yes	No	Sensitivity to sweets	Yes	No
Teeth straightened	Yes	No When_____	Bleeding gums	Yes	No
Unpleasant taste	Yes	No	Frequent Headaches	Yes	No
Popping clicking noises in jaw	Yes	No	Clenching or grinding	Yes	No
			Frequent daytime fatigue	Yes	No

Date of last Dental exam_____ Why are you seeking care at this time? _____

Do you drink soda? Yes No Cans per day: _____ Do you smoke? Yes No Chew tobacco? Yes No

PRIMARY DENTAL INSURANCE INFORMATION

Name of Insurance Carrier_____ Group #_____

Ins Company Phone Number_____ Subscriber Employer _____

Name of Subscriber_____D.O.B._____Suscriber SS#_____

SECONDARY DENTAL INSURANCE INFORMATION (if applicable)

Name of Insurance Carrier_____ Group #_____

Ins Company Phone Number_____ Subscriber Employer _____

Name of Subscriber_____D.O.B._____Suscriber SS#_____

FINANCIAL AGREEMENT AND AUTHORIZATION

Financial Policy of the Dental Health Center

Financial consideration should not be an obstacle to obtaining this important, life-enhancing care. We are always available to answer your questions and/or assist you in any way we can.

For Our Patients With Insurance: We are happy to assist you in filing the necessary forms to help you receive the full benefits of your coverage, however you are ultimately responsible for knowing what your benefits coverage consists of. To better assist you, we are familiar with many insurance plans and will calculate *as best we can* what your co-payment and deductible will be and this will be discussed with you prior to your treatment. However, we are not responsible for how much or when your insurance company pays on your claim. We ask to have your portion paid within 30 days of your treatment. This minimizes the need to send statements, thereby allowing us to offer affordable dental treatment.

For Our Patients Without Insurance: We expect payment in full on the day services are rendered and have three payment options available for you:

- ✓ Payment in full with a 15% discount. We also accept all major credit cards with a 12% discount.
- ✓ Interest free financing through Care Credit and Citibank
- ✓ In office arrangements **prior** to treatment

*Seniors (62 and older) receive a 10% discount **plus** another 5% paid day of service with cash or personal check (12% discount if paid by credit card on day of service).

**Discounts do not apply to certain insurance companies or special packages*

**Discounts may not be combined*

In order to best accommodate our patients and keep our schedule full, we require ***2 business days*** notice should you need to change an appointment. Appointments changed with less notice than this will be assessed a $25 fee. Missed appointments will be charged $30. Also note, there will be a $35 service charge applied for all returned checks.

I certify that I have read and understand the above information to the best of my knowledge. I authorize my insurance company to pay directly The Dental Health Center any insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents, regardless of insurance coverage.

YOU WILL SIGN THIS EXACT FORM ON THE SIGNATURE PAD ONCE IT IS ENTERED INTO THE COMPUTER. PLEASE ASK IF YOU WOULD LIKE A COPY FOR YOUR RECORDS.

MEDICAL INFORMATION

(Women) Are you taking birth control pills? Y N Are you pregnant? Y N Are you breastfeeding? Y N

Are you currently under the care of a physician? Y N If yes, for what reason? _____

Please list all allergies you have_____

Have you ever been advised to pre-medicate with antibiotics before having dental treatment? Yes No

Have you ever taken Fosamax, Boniva, Actonel, or any cancer medications containing biophosphonates? Yes No

Please list all medications you are presently taking, including aspirin/baby aspirin and Cancer medications (Zometa/Aredia). _____

_____

DO YOU HAVE OR HAVE YOU EVER HAD:

Arthritis	Yes	No	Rheumatic fever	Yes	No
Asthma or hay fever	Yes	No	Chemical Dependency	Yes	No
Congenital heart defects	Yes	No	Fainting or seizures	Yes	No
Abnormal blood pressure	Yes	No	Excessive urination/thirst	Yes	No
Diabetes	Yes	No	Malignant Hypothermia	Yes	No
Epilepsy	Yes	No	HIV Positive	Yes	No
Cancer	Yes	No	Excessive/prolonged bleeding	Yes	No
Psychiatric care	Yes	No	Taking blood thinner	Yes	No
Radiation therapy	Yes	No	Sinus trouble	Yes	No
Stroke	Yes	No	Thyroid problem	Yes	No
Prosthetic implant	Yes	No	Pace Maker	Yes	No
Tuberculosis or lung disease	Yes	No	Tumors	Yes	No
Hepatitis	Yes	No	Kidney disorders	Yes	No
Herpes simplex (cold sores)	Yes	No	Heart disease	Yes	No
Latex Allergy	Yes	No	Heart attack	Yes	No
Circulatory problems	Yes	No			
Heart Murmur	Yes	No			

Is there anything else I should know about your medical history? _____

Primary Care Physician and Clinic _____

You do not need to sign this form as we will enter this into the computer and have you sign an electronic signature pad.

When I sign the form electronically, I certify that I have read and understand the above information to the best of my knowledge.