Weldon General and Cosmetic Dentistry

Daniel A. Weldon, DMD, PLLC

Our team at Weldon General and Cosmetic Dentistry looks forward to taking care of your dental needs. As a patient of Drs. Weldon and Berg, we would like to inform you of our office policies. The following policies have been set to help us provide the highest quality of dental care to our patients. We value our relationship with our patients and will be happy to assist you with our office policies and procedures.

Patients without Dental Insurance

We accept Cash, Checks, All major Credit Cards, and Care Credit. All payments are due at the time services are rendered.

Patients with Dental Insurance

As a courtesy to you, we file and accept payment from many different insurance plans. All plans have their own schedule of covered services according to what plan your employer has purchased. The front desk staff will estimate the amount you owe for procedures that have been recommended. Remember, this is only an estimate. The actual out-of-pocket expense may be less than or greater than the amount estimated and collected. There is no guarantee that services will be covered. You will be responsible for payment of non-covered procedures. You may be reimbursed or apply any excess to a future date of service if we have collected too much.

We do ask that you familiarize yourself with your insurance policy and the way it works. Some insurance plans require the patient to pay a percentage or co-payment directly to our office. Some plans require the patient to pay the entire amount due for that visit. Some plans will only reimburse the covered amount to the patient. In that case, we will either file or give the correct forms necessary to receive reimbursement as a courtesy and you will be required to pay us in full at the time of service. **We file your dental insurance as a courtesy and anything not paid by the insurance company is your responsibility.**

Major Treatment

Patients receiving major treatment (Crowns, Implants, Veneers, Dentures, etc.) must have their portions paid in full before delivering or cementing the case.

Cancellation Policy

Our office respects your time and we take pride in spending undivided attention with each and every patient. In order for us to schedule properly, we request that you arrive promptly to all of your appointments. **If you arrive greater than 10 minutes late we may have to reschedule your appointment. A cancellation fee of $50.00 per hour that you are scheduled for hygiene and $100.00 per hour that you are schedule with Dr. Weldon will be applied to all broken, failed or missed appointments unless 48 business hours are verbally given to our office.** If you are unable to reach a staff member at the office you can leave us a message at (352-622-3236) or you can email our office: frontdesk@weldondentistry.com.

Finance Charges

Payment is due in full at the time services are rendered. Any outstanding balance 30 days past due will incur a 10% finance charge. We do accept Cash, Checks, All major Credit Cards, and Care Credit.

I have read and understand all office policies of Weldon General and Cosmetic Dentistry.

_____ _____

Signature of Responsible Party Date

Weldon General and Cosmetic Dentistry

Daniel A. Weldon, DMD, PLLC
812 NE 25th Ave., Suite B
Ocala, FL 34470
(352)622-3236

General Information:

Patient Name: _____ **Birthdate:** _____/_____/_____

Address: _____ **Male** ____ **Female** ____

City, State, Zip: _____ **Marital Status:** S M D W

Home # (____) _____ **Cell #** (____) _____

Work# (____) _____ **Email:** _____

Social Security #: _____/_____/_____ **Driver's License:** _____

Employer: _____ **Referred By:** _____

Spouse or Parent's Name: _____

Responsible Party Information:

Responsible Party: _____ **Phone #** (____) _____

Address (If different from above): _____

Insurance Information:

Policy Holder Name: _____ **Employer:** _____

Policy Holder SSN: _____/_____/_____ **AND** **Member ID #:** _____

****If we have trouble verifying your policy with ID number insurance company can verify with SSN****

Insurance Company: _____ **Phone #:** (____) _____

Address: _____ **Group #:** _____

_____

I hereby authorize and request dental treatment from Daniel A. Weldon, DMD, PLLC and John F. Berg, DDS, PA., and further authorize the performance and the administration of any anesthetics and analgesics which the above named doctor may deem necessary.

_____ _____

Signature Date

Daniel A. Weldon, DMD

Date 12/17/2020

Medical History 2017

Patient Name: Birth Date: Date Created:

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

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes
Other?	☐	If yes

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

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

Have you ever had any serious illness not listed above? ◯ Yes ◯ 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:_____

Signature of Provider:

X Date:_____

Are you currently, or have you ever been treated for any of the following conditions? Circle yes or no.

Osteoporosis	Yes	No
Osteoarthritis	Yes	No
Osteopenia	Yes	No
Multiple Myeloma	Yes	No
Cancer metastasis to bone	Yes	No

Have you ever taken or been prescribed any of the following medications? If so please indicate dosage and duration. Circle yes or no.

Reclast injection	Yes	No
Aredia IV (Pamidronate)	Yes	No
Zometa IV (Zoledronate)	Yes	No
Boniva (Ibandronate)	Yes	No
Fosamax (Alendronate)	Yes	No
Actonel (Risedronate)	Yes	No
Didronel (Etidronate)	Yes	No

Patient Signature:_____ Date:_____

Print Name:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.
****You may refuse to sign this acknowledgement****

I, _____, have received a copy of office's Notice of Privacy Practices.

Print Name: _____
Signature: _____
Date: _____

Authorization to Release Information

Purpose: This form is used to obtain authorization to release information regarding you covered under the Privacy Act to people other than yourself. I, _____, authorize the following person(s) to have access to information covered under the Privacy Practice regarding myself:

_____
(Please Print Name and Relationship)

_____
(Please Print Name and Relationship)

_____
(Please Print Name and Relationship)

For Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify) _____