

Weldon General and Cosmetic Dentistry

Daniel A. Weldon, DMD, PLLC

John F. Berg, DDS, PA

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 we may have to reschedule your appointment. A cancellation fee of \$25.00 will be applied to all broken or missed appointments unless 24 hours is given.** If you are unable to reach a staff member at the office you can leave us a message at any time (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

John F. Berg, DDS, PA

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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

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

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