Gary J. Wokuluk, D.D.S.

Referral Information

Name of person or office referring you to our practice: ____

Patient Information

Patient Name____ Date: __________
Last, First MI (Preferred Name)

Gender: ______ Family Status: __________ Social Security #__ ______________ Birth Date: ______________ Age____ ____

Phone (Home): ______________ (Work): ______________ Ext: ________ (Cell)______________

E-mail Address: ____

Address: ____
Street Apartment #

____
City State Zip Code

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Insurance ID or SSN #: ______________________ Birth Date: ______________

Phone (Home): ______________ (Work): ______________ Ext: ______ Best time to call: __________

Address: ____
Street Apartment #

____
City State

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: ______________________ Occupation: ______________

Address: ____ ______________
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

____

Secondary

Name of Insured: ______________________________ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: ______________ ID #: ______________ Group #: ______________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Address: ____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ______________

Insurance Plan Name and Address: ____

Gary J. Wokuluk, D.D.S. - *Health History*

AIDS	Y	N	Cosmetic Surgery	Y	N	Hepatitis (A B C)	Y	N	Scarlet Fever	Y	N
Allergies, Hives or Hay fever	Y	N	Diabetes	Y	N	High / Low Blood Pressure / Hypertension	Y	N	Severe Headaches	Y	N
Anemia	Y	N	Difficulty Breathing	Y	N	Kidney Disease	Y	N	Stroke	Y	N
Angina Pectons	Y	N	Drug Addiction	Y	N	Liver Disease	Y	N	Substance Abuse	Y	N
Arthritis	Y	N	Dry Mouth	Y	N	Mental Disorders or Psychiatric Treatment	Y	N	Taken Phen-Phen	Y	N
Artificial Heart Valve	Y	N	Emphysema	Y	N	Mitral Valve Prolapse	Y	N	Taken Redux	Y	N
Artificial Joints Date Placed_______	Y	N	Epilepsy or Seizers	Y	N	MRSA	Y	N	Thyroid Condition	Y	N
Asthma	Y	N	Excessive Bleeding	Y	N	Nervous Disorders	Y	N	Tuberculosis	Y	N
Blood Transfusion	Y	N	Fever Blisters	Y	N	Pacemaker	Y	N	Ulcers	Y	N
Bruise Easily	Y	N	Fainting or Dizzy Spells	Y	N	Pain in Jaw Joints	Y	N	Venereal Disease/ Syphilis, Gonorrhea, Etc.	Y	N
Cancer	Y	N	Head Injuries	Y	N	Pregnancy Due Date ________	Y	N	Yellow Jaundice	Y	N
Chemo/Radiation	Y	N	Heart Murmur	Y	N	Prostate Trouble	Y	N	Taking Blood Thinners	Y	N
Circulatory Problems	Y	N	Heart Problems ___________________	Y	N	Radiation or X-ray Treatment	Y	N	Sleep Apnea	Y	N
Congenital Heart Lesions	Y	N	Hemophilia	Y	N	Rheumatic Fever	Y	N	Treated for Osteoporosis	Y	N
Cortisone Medication	Y	N	Herpes/Shingles	Y	N	Respiratory Problems	Y	N			

Are you allergic or have you reacted adversely to any of the following? (Circle)

Aspirin Acetaminophen Ibuprofen Amoxicillin Latex Darvon Nitrous Oxide
Local Anesthetic Percodan Valium Clindamycin Penicillin Erythromycin

Are you aware of being allergic to any other medications? YES NO

If yes, please list____

____

Please list any health issues the Doctor should be aware of:

____

____

____

____

____

____

____

____

Gary J. Wokuluk, D.D.S. - ***Health History***

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______

List Current Medications you are now taking including any over the counter drugs:

______

______

______

Name of Physician: ______ If Kaiser MR#	Phone:
Name of Previous Dentist: ______	Phone:

Dental History

Date of Last COMPLETE dental exam ______
Date of last FULL MOUTH XRAY ______
Are you having problems now? **Y N**
If yes, explain ______
Is your present dental health POOR? **Y N**
Do you regularly use dental floss **Y N**
Do you wear Dentures, Partials or Full **Y N**
If so, are you unhappy with your dentures? **Y N**
Would you like to know about permanent replacements ? **Y N**
Have you worn braces (orthodontics)? **Y N**
Do you have breaking teeth or fillings **Y N**

Have you had bad dental experiences in the past ? **Y N**
Are you apprehensive about dental treatment **Y N**
Have you had any periodontal (gum) treatments? **Y N**
Do your gums bleed, or feel tender or irritated? **Y N**
Are your teeth sensitive to:
HOT COLD SWEETS PRESSURE (circle)
Are you unhappy with the appearance of your teeth **Y N**
Are you aware of grinding or clinching your teeth **Y N**
Do you have headaches, earaches or neck pains? **Y N**
Do you have **LOOSE TIPPED** or **SHIFTING** teeth (circle)
Do you have discolored teeth that bother you? **Y N**
Would you like your smile to look better or different? **Y N**

Would you like us to help you learn proper methods of home care, so you can stop dental problems in your mouth? **Y N**

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______ Date: ______
Signature of patient, parent or guardian

Consent for Services

I authorize the Doctor to take x-rays, study models, photos, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I understand the use of anesthetic agents embodies certain risk.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment. **A 24 hour notice of change or cancellation is required**. **Patients failing to give 24 hour notice are subject to a $40.00 charge**.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.
Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I assign any insurance benefits to the Doctor.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.
I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I authorize release of information to my insurance company and authorize their direct payment to your office.

I give my consent to all agreed upon dental treatment for myself or dependent. I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

______ Date: ______ Relationship to Patient: ______
Signature of patient, parent or guardian

______ Date: ______ Relationship to Patient: ______
Signature of guarantor of payment/responsible party

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Health Insurance Portability Accountability Act (HIPAA), 1996
http://www.hhs.gov/ocr/hipaa/finalreg.html

SECTION A: PATIENT/GUARDIAN GIVING CONSENT

Name: ____

Address:____

Telephone: ____

SECTION B: TO THE PATIENT/GUARDIAN — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Gary J. Wokuluk, DDS, 119 W. Lexington Ave., El Cajon, CA 02021, Phone 619-444-0412

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I hereby give my consent to Dr. Wokuluk's office to discuss my treatment and finances involved in it with:

____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. PLEASE ADVISE US IF YOU WANT A COPY.

I, ____, have received acknowledgement of this office's Notice of Privacy Practices and agrees to them.

____ Date:_______________________________
SIGNATURE PATIENT/PARENT

PATIENT/ PARENT ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET.
You have been given a booklet , "The Facts About Fillings" . This dental materials fact sheet is made in an effort to assist you in understand the materials used in dentistry and their risk, benefits and alternatives.

____ Date__________________________
(BOOKLET AT FRONT DESK)
SIGNATURE PATIENT/PARENT

For Office Use:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
0 ____ Individual refused to sign
0 ____ Communications barriers prohibited obtaining the acknowledgement
00 ____ An emergency situation prevented us from obtaining acknowledgement
00 ____ Other (Please Specify)