5258 Montgomery Rd.
Cincinnati, OH 45212

P: 513.531.2338
F: 513.841.5545

Patient Information

Patient Name: (Last, First, Middle Initial)	
Address:	Male □ Female □
City: St. Zip:	Married □ Single □ Child □ Other □
How long at this address?	Rent □ or Own □
E-mail:	SSN:
Birth date:	Drivers License #:
Your Employer - with address:	
How do you prefer to be notified of your appointment? Email Phone Call (Cell, Home, or Work)	

Like us on Facebook to be entered into raffles and win prizes!!!

Phone Numbers

Home Phone: ( )	Work Phone: ( )
Cell Phone: ( )	
In case of an emergency, please contact:	Emergency Contact Phone: ( )
Relationship:	
How did you hear about us (Circle One)? Google Angie's List Patient Referral (Who?) Other (How?)	

Insurance & Financial Responsibility

Who is the party responsible for payment?	
Who is the Subscriber of Insurance (if different than patient)?	
Subscriber ID:	Relationship to Patient?
Insurance Company:	
Group Number:	Group Plan Name:
Is patient covered by additional insurance?	Yes □ No □ (If yes, complete next)
Subscriber's Name	Birth date:
Relationship:	SSN:
Insurance Company:	
Group Number:	Group Plan Name:

Insurance Assignment: *I certify that I, and/or my dependents, have insurance coverage with the insurance company above and I assign directly to The Wallace Group Dentistry for Today, Inc. all insurance benefits, if any, otherwise payable to me for services rendered.*

Financial and Personal Health Information: *I understand that I am financially responsible for all charges incurred during treatment. I further understand that any insurance contract is between my insurance carrier and me and The Wallace Group Dentistry for Today, Inc. and/or Dr. Wallace is not part of that contract. (As a courtesy to our valued patients we will submit your insurance forms initially. If problems occur with the insurance portion of your obligation, the balance in full will become due in thirty (30) days. We will provide information to assist with your carrier.)*

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Service Charges: *I understand that a Service Charge will be imposed on each item of my account which has not been paid within thirty (30) days of the time the item was added to the account. The Service Charge will be computed at the rate of one and one-half percent (1.5%) per month or an Annual Percentage Rate of eighteen percent (18%). Further, I understand that the Service Charge on my account is computed by applying the periodic rate (1.5%) to the overdue balance of my account. The overdue balance is calculated by taking the balance owed thirty (30) days ago, and then subtracting any payments or credits applied to the account during that time. The Minimum Service Charge is $0.50.*

Past Due Accounts: *I also understand that if my account becomes past due, all necessary steps will be taken to collect the debt. If the account is referred to a collection agency or a claim filed in court, I agree to pay all of the collection costs which are incurred. If the account is referred to a lawyer for collection, I agree to pay all lawyers' fees which are incurred plus all court costs. In case of suit, I agree the venue shall be Hamilton County, Ohio.*

Returned Checks: *I have been advised that there is a Thirty-Five Dollar ($35.00) fee for any checks returned by my bank.*

Missed Appointment Fee: *Please provide a 24-hour notice for any cancellation to avoid a cancellation fee. We have reserved that time especially for you. The current cancellation fee is $40.00.*

Privacy Policies: *I have received or have been offered a copy of The Wallace Group Dentistry for Today, Inc.'s* Notice of Privacy Policies. *I understand that The Wallace Group Dentistry for Today, Inc. and/or Dr. William Wallace may use my health care information and may disclose such information for treatment, payment, and health care operations.*

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative | *Date*

_____ _____

Printed Name of Patient, Parent, Guardian or Personal Representative | *Relationship to Patient*

Reason for Today's Visit

_____

_____

Information Sharing

With whom may we share information regarding your treatment or account? Name: _____ Relationship _____

Bisphosphonates

Have you ever or are you currently taking or scheduled to begin taking any of the medications, alendronate (Fosamax®), risedronate (Actonel®) or ibandronate (Boniva®) for **osteoporosis** or Paget's disease? □ **YES** □ **NO**

Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia®) or Zometa®) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer? □ **YES** □ **NO**

Date Treatment Began _____/_____/_____

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Wallace Group Dentistry Est. 1977 Norwood, Ohio

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Dental History

Please place a checkmark if you have had or currently have any of the following:

□ Bad Breath	□ Cigarette, pipe or cigar smoking	□ Grinding teeth	□ Sensitivity to sweets
□ Bleeding Gums	□ Dry mouth	□ Lip or cheek biting	□ Sensitivity when biting
□ Blisters on lips or mouth	□ Fingernail Biting	□ Loose teeth or broken filings	□ Sores or growths on mouth
□ Burning sensation on tongue	□ Food collection between teeth	□ Mouth breathing	□ Swollen or tender gums
□ Chew on one side of mouth	□ Foreign objects	□ Sensitivity to heat or cold	□ Other

How often do you brush? _____

How often do you floss? _____

Medications

List any medications you are currently taking and the correlating diagnosis:	
Pharmacy Name:	
Phone: ( )	

Allergies

List any allergies:

Health History

Please place a checkmark if you have had any of the following:

AIDS/HIV	□	**Hepatitis Type _____**	□
Tuberculosis	□	**Cough, Persistent/Bloody**	□
Diabetes	□	Kidney Disease	□
Artificial Heart Valves	□	Liver Disease	□
Asthma	□	Low Blood Pressure	□
Bleeding abnormally during surgery	□	Pacemaker	□
Cancer	□	Radiation Treatment	□
Chemotherapy	□	Respiratory Disease	□
Congenital Heart Lesions	□	Scarlet Fever	□
Emphysema	□	Shortness of Breath	□
Epilepsy	□	Sinus Trouble	□
Heart Problems	□	Stroke	□
Herpes	□	Swollen Feet or Ankles	□
High Blood Pressure	□	Tumor or Growth on head/neck	□
Jaw Pain	□	Other:	□