



Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

11 Wells Street • PO Box 2058 • Westerly, RI 02891-0917 • Phone 401-596-0888

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

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, please explain: _____
- Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
- Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
- Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____
- Do you take, or have you taken, Phen-Fen or Redux? Yes No _____
- Are you on a special diet? Yes No _____
- Do you use tobacco? Yes No _____
- Do you use controlled substances? Yes No _____

Women: Are you
Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

- 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 | Renal Dialysis <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 | Rheumatic Fever <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 | Rheumatism <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 | Scarlet 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 | Shingles <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 | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease <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 | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble <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 | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida <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 | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease <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 | Leukemia <input type="radio"/> Yes <input type="radio"/> No | Stroke <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 | Liver Disease <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease <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 | Lung Disease <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <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 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis <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 | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths <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 | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No | Ulcers <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 | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice <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 | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No | |

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 _____ DATE _____



Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

11 Wells Street • PO Box 2058 • Westerly, RI 02891-0917 • Phone 401-596-0888

Financial and Collection Policy for Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D.

The following is a summary of our financial and collection policy.

- We expect payment on the day of service from our patients without dental insurance, with Delta Dental and Blue Cross, and with any other insurance, which directs payment to the patient.
- All co-payments are expected at the time of service for those patients who have dental insurance that will pay directly to our office.
- We do periodically increase our fees to cover the rising costs of dental supplies, utilities, staff, and all other costs associated with the day-to-day operations of our office.
- If your family is involved in a divorce situation **the parent that brings their child(ren) to our office for care is the parent that is responsible for us for the full amount of services rendered to the child(ren)**. We will not get involved with your personal or court ordered arrangement.
- We do bill you if you miss or cancel an appointment with short notice. You may be billed up to the full fee for the services that were to be performed at that appointment. If there are three (3) missed appointments we may choose to dismiss you from our practice.
- In the event that there is a balance on your account, you are given thirty (30) days to pay the balance in full. At thirty (30) days your account will be assessed a re-billing fee of \$3.00, at sixty (60) days \$5.00, and from there forward \$8.00 per month until the balance is paid in full. If your account reaches ninety (90) days then your account will be forwarded to a collection agency and you will be dismissed from our practice. You will be billed for any charges incurred in collecting past due fees.
- We want you to have the care that is appropriate and necessary to maintain your dental health. We may be able to assist you with financing your care depending upon your needs.
- If you should require copies of your dental records for a second opinion, or to transfer your care to another dental provider, you will be charged a \$25.00 fee, per patient, for electronic processing and the secure electronic transmission of your records. If they cannot be transmitted electronically, then they will be mailed.

I, _____, have received a copy of this office's Financial and Collection Policy and agree to abide by them.

Signature

Date



Rebecca J. Woodward, D.M.D.
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- We do bill you if you miss or cancel an appointment with short notice. You may be billed up to the full fee for the services that were to be performed at that appointment. That fee may be forwarded to a local charity. If there are three (3) missed appointments we may choose to dismiss you from our practice.
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AUTHORIZATION FOR SIGNATURE ON FILE
AUTHORIZATION OF PAYMENT/RELEASE OF INFORMATION
AND FINANCIAL RESPONSIBILITY

I _____, understand and agree that I am responsible for all charges incurred regardless of insurance coverage. I understand that Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D. have accepted the insurance company's verification of coverage and benefits in good faith that the claim will actually be covered as described by the insurance company. In the event that the insurance company does not cover the claim for the verified benefits, I agree to be responsible for all charges for dental services and materials, which I and/or my dependents have incurred and authorized in my and/or my dependents treatment. I agree that any balance not paid by my insurance company within 60 (sixty) days will be my responsibility to pay. I agree to furnish the insurance company and Drs. Woodward and Kaufman with any additional information or paperwork requested to expedite payment of my claim. To the extent permitted under applicable law, I hereby authorize release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependents. I hereby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D. I agree that a photocopy of this document and authorization may act as an original and that my signature below shall authorize payment to the dentist for any services rendered to my dependents or me as if I had signed each benefit of future claims.

I hereby authorize payment of dental benefits otherwise payable to me, directly to the office of Rebecca J. Woodward, D.M.D. and Adam S. Kaufman, D.M.D. This "Signature on File" will be valid from this date forward. A photocopy of this document may act as an original.

TODAY'S DATE

SIGNATURE OF INSURED

WITNESSED BY



Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.

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PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec.: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Cell Phone #: _____

Credit Card #: _____

Please confirm at: _____

Last FMX:: _____

Last PANO:: _____

Last BWX:: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City,State,Zip: _____ City,State,Zip: _____

Rem. Benefits: .00 Rem. Deduct: .00



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Request for Release of Records

I, hereby, release all dental records, including radiographs and daily treatment notes, from the office of Dr. _____, located at
(Previous Dentist)

_____,
(Address of Previous Dentist)

to Rebecca J. Woodward, D.M.D. and/or Adam S. Kaufman, D.M.D.
I also release you from all legal responsibility or liability that may arise from this authorization.

Please send my records via email to: info@westerlydentists.com

If you cannot email my records, then please send them to:

Rebecca J. Woodward, D.M.D.
Adam S. Kaufman, D.M.D.
11 Wells Street
P.O. Box 2058
Westerly, RI 02891
Phone: (401) 596-0888
Fax: (401) 596-9710

Signature _____ Date _____
(Patient or Person Authorized to Consent for Patient)

Patient's Name _____
Address: _____



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New Patient Agreement

We are an office that focuses on preventive oral care. The following is a list of what we require from you as our patient:

1. Radiographs must be taken when needed. We take radiographs based on **individual patient need**, not based upon a schedule. We offer the most up to date technology and have invested in digital radiography, which exposes you to less radiation than traditional film radiography while providing superior diagnostic value.
2. Children must have a panoramic xray taken by the time they are 9 yrs old. It is important to be sure that all adult teeth are present and in their proper location.
3. We require that you have a clinical hygiene appointment and dental examinations on a regular basis. We recommend that these services be performed as needed based upon your periodontal condition. We require that you come at least every 12 months to remain an active patient in our practice.
4. We perform a dental examination at every clinical hygiene appointment. Your hygienist performs a hard and soft tissue exam, periodontal exam, TMJ exam, caries exam, head and neck exam, and oral cancer screening at every hygiene appointment. The doctor may reexamine if necessary. These services are all included in the Periodic Oral Exam fee.
5. **To keep the cost of dentistry down we do require 48-hour notice to reschedule any appointments.** We encourage you to try to keep your scheduled appointments, however if there is no possible way that you can make the time that we reserved for you we ask that you call during office hours to reschedule your appointments. Please speak directly to one of our Patient Care Coordinators. It is important that we have as much notice as possible so that another patient who needs care has the opportunity to take the time that was reserved for you.

If you miss your appointment, or cancel within 48 hours of your appointed time, then we may charge you a broken appointment fee. This fee will need to be paid before we will reappoint you. If you fail to keep another appointment in the future, then you may be charged up to the full fee for the services that were to be provided at that appointment. The third failed appointment will result in a charge and possible dismissal from the practice.

6. The doctors will propose treatment options that are most likely to improve your individual, long-term dental health. Your dental benefits may not cover all, or any, of the recommended options. **Your dental benefits are an adjunct and helpful, but not necessarily comprehensive.** With the exception of Mashantucket Pequot Benefits, we are a non-participating office. We submit all dental claims for you. Most Delta Dental and Blue Cross of RI plans send the check directly to the patient, so if you have one of those benefit plans, you most likely will be required to pay for your services, in full, at the time of your appointment. Your benefit company will reimburse you directly. Other plans may require you to pay a portion of the fee for your services and that is also due at the time of service. You may call our office or your dental benefit company directly if you have further questions.

I, _____, have read the above and agree to comply with these requirements.

Signature _____ Date _____
(Patient or Person Authorized to Consent for Patient)



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3. We require that you have a clinical hygiene appointment and dental examinations on a regular basis. We recommend that these services be performed as needed based upon your periodontal condition. We require that you come at least every 12 months to remain an active patient in our practice.
4. We perform a dental examination at every clinical hygiene appointment. Your hygienist performs a hard and soft tissue exam, periodontal exam, TMJ exam, caries exam, head and neck exam, and oral cancer screening at every hygiene appointment. The doctor may reexamine if necessary. These services are all included in the Periodic Oral Exam fee.
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