Patient Application

THE ART OF DENTISTRY

Gregory J. Wych, DDS
7505 St. Andrews Road
Irmo, South Carolina, 29063
Phone: **803.781.1600**

Patient Information

Last Name _____ First Name _____ Middle Name _____

Gender _____ Social Security # _____ Date of Birth _____ Preferred Name _____

Relationship Status: ☐ Single ☐ Married ☐ Minor ☐ Separated ☐ Divorced ☐ Widowed ☐ Common-law for _____ years

Street Address _____ Apt. # _____ City _____ State _____ Zip Code _____

Home Phone # _____ Mobile Phone # _____ Primary E-Mail _____

Employer / School _____ Employer / School Phone _____

Spouse / Parent's Name _____

How did you hear about our office? _____

Person to contact in case of emergency _____ Phone # _____

Dental Insurance Information

Name of Insured _____ Relation to patient _____

Date of Birth _____ Social Security # _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Company Address _____ City _____ State _____ Zip Code _____

Secondary Dental Insurance Information

Name of Insured _____ Relation to patient _____

Date of Birth _____ Social Security # _____

Employer _____ Work Phone # _____

Employer Address _____ City _____ State _____ Zip Code _____

Insurance Company _____ Group # _____ Union or Local # _____

Insurance Company Address _____ City _____ State _____ Zip Code _____

Medical History

Physician's Name _____ Date of last visit _____

Specialist Name _____ Date of last visit _____

1. Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine), Pondimin (Fenfluramine) and Redus (Dexfenfluramine)? ☐ Yes ☐ No Have you ever taken diet pills? _____
2. Have you ever had any serious illness or operations? ☐ Yes ☐ No
   If yes, please explain _____
3. Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate date _____
4. (Women) Are you pregnant? ☐ Yes ☐ No Are you nursing? ☐ Yes ☐ No Are you taking birth control pills? ☐ Yes ☐ No
5. Have you ever taken or currently taken St. John's Wort? ☐ Yes ☐ No
6. Do you have Sleep Apnea? ☐ Yes ☐ No Do you use a CPAP Machine or Supplemental oxygen therapy? ☐ Yes ☐ No
7. **DO YOU OR HAVE YOU** ever taken bone density medications? ☐ Yes ☐ No If yes :_____
8. Do you receive any injections that your physcian administers? ☐ Yes ☐ No If yes:_____
9. Have you ever had any of the following?

☐ Acid reflux
☐ Anemia
☐ Arthritis, Rheumatism
☐ Artificial Heart Valves
☐ Artificial Joints
Date_____
☐ Asthma
☐ Back Problems
☐ Bleeding Abnormally
☐ Blood Disease
☐ Cancer
☐ Cardiovascular Accident
Date_____
☐ Cardiovascular Surgery
Date_____
☐ Chemical Dependence
☐ Chemotherapy
☐ Cholesterol
☐ Circulatory Problems
☐ Congenital Heart Lesions
☐ Cortisone Treatments
☐ Cough, Persistent
☐ Cough up Blood
☐ Diabetes
☐ Epilepsy
☐ Fainting
☐ Glaucoma
☐ Headaches
☐ Heart Murmur
☐ Heart Problems
☐ Heart Stent
Date_____
☐ Hemophilia
☐ Hepatitis Type? _____
☐ Herpes Type 1
☐ High Blood Pressure
☐ HIV/AIDS
☐ HPV
☐ Kidney Disease
☐ Liver Disease
☐ Mitral Valve Prolapse
☐ Mitral Valve Replacement
☐ Osteopenia
☐ Osteroporosis
☐ Pacemaker
☐ Radiation Treatment
☐ Recreational Drug Use
☐ Respiratory Disease
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Shortness of Breath
☐ Skin Rash
☐ Staph Infection
☐ Stroke
☐ Swelling of Feet or Ankles
☐ Thyroid Problems
☐ Tobacco Habit
☐ Tonsillitis
☐ Tuberculosis
☐ Ulcer
☐ Venereal Disease/STD
☐ Do you partake in alcohol daily?
☐ Yes ☐ No

List any medications or supplements you are currently taking and the correlating diagnosis: _____

Allergies:

Dental History

Date of last dental care _____

Former dentist _____ Date of last dental X-rays _____

Street Address _____ Apt. # _____ City _____ State _____ Zip Code _____

Has had the following problems:

- ☐ Bad breath
- ☐ Bleeding gums
- ☐ Clicking or popping jaws
- ☐ Food collection between the teeth
- ☐ Grinding teeth
- ☐ Loose teeth or broken fillings
- ☐ Periodontal treatment
- ☐ Sensitivity to cold/heat
- ☐ Dental anxiety
- ☐ Sensitivity to sweets
- ☐ Sensitivity when biting
- ☐ Sores or growths in your mouth

How often do you floss? _____ How often do you brush? _____

Smile Analysis

When I see a picture of myself, the first thing I notice about my smile is? _____

What do you consider attractive in another person's smile? _____

Please check any statement you agree with:

- ☐ I wish the color of my teeth were whiter.
- ☐ I wish I had a bigger smile.
- ☐ I think some of my teeth are too large.
- ☐ I wish my teeth were straighter.
- ☐ I think my gums show too much when I smile.
- ☐ I think my smile shows too much space between some of my teeth.
- ☐ Because I am not totally pleased with my smile, I sometimes hesitate to smile.
- ☐ I have often wished I could change some of the features of my smile.
- ☐ I feel as though I don't really know all the options available to enhance my smile.
- ☐ Concerns over what the end result might look like, have been a factor in my not having aesthetic dentistry in my own mouth.
- ☐ Concerns over the fees have prevented me from taking advantage of some of the available options to enhance my smile.
- ☐ I feel as though I could do a better job protecting the health of my teeth and gums, and therefore, the longevity of my own smile.

I authorize the use of my radiographs and/or photographs for the use in seminars or publications of The Art of Dentistry.

Signature _____

E-mail _____

Notice of Privacy Practices

THE ART OF DENTISTRY

Gregory J. Wych, DDS
7505 St. Andrews Road
Irmo, South Carolina, 29063
Phone: **803.781.1600**

Patient Acknowledgement of Receipt of Notice of Privacy Practices

PLEASE PRINT

I, _____ hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy* upon request.

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: _____ Date: _____/_____/_____

Name: _____
PLEASE PRINT

Relationship to Patient: _____

For Office Use Only

We made a good-faith effort to obtain an acknowledgement of _____'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgement of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) _____/_____/_____.

☐ Communication barriers prohibited obtaining an acknowledgement.

☐ An emergency situation prevented us from obtaining an acknowledgement.

☐ Other_____

Attempt was made by: _____ Date: _____/_____/_____

I certify that I, and/or dependent(s), have insurance coverage with the stated dental insurance and assign directly to Dr. Wych all insurance benefits. If any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. The consent will end when the current treatment plan is completed or one year from the date signed below. To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature _____ Date _____