

# Welcome to our Office !

## WNC Dental

J. Randall Latta, DDS & Associates, PA

Dear Patient,

Thank you for choosing our practice for your dental health needs.

How did you hear about us? \_\_\_\_\_

### About Us

We are a group of dentists and staff who have come together to form a private practice dedicated to helping you achieve your best dental health and appearance. We accept all dental insurance including Aetna, BCBS, Delta Dental and Medicaid and many others in addition to private pay in order to help you manage your dental costs. As a courtesy we will file your dental claim with your insurance company but the deductible, co-pay, or balance after insurance will be due at the time of service

### Our Responsibilities

- To always respect your privacy
- To diagnose your dental conditions to the best of our abilities
- To fully discuss with you our findings and your wishes in order to agree on a dental treatment plan to restore you to better dental health
- To perform our treatments according to the Standards of Care and give instruction and recommendations in your best interests

### Your Responsibilities (please initial to agree)

- I will disclose all required personal information and medical history including notifying us immediately of changes if they occur. \_\_\_\_\_(initial)
- I will show up for all appointments and be on time. \_\_\_\_\_(initial) If you are more than 15 minutes late for your appointment, you may be rescheduled for another day (Missed appointments make it impossible to maintain a proper doctor-patient relationship and to complete your accepted treatment plan, and may result in discontinuing me as a patient. We consider it only fair that others who are waiting for our services and are able to keep their appointments be given their turn.)
- I will follow my doctor's post-treatment instructions for proper healing and comfort to promote the best results \_\_\_\_\_(initial)

We hope you are in agreement with these Office Policies and are looking forward to this opportunity to receive dental care in a comfortable and relaxed environment. **We look forward to treating you!**

I agree \_\_\_\_\_  
Name (Patient or Guardian)

\_\_\_\_\_ Date

# WNC Dental

J. Randall Latta, DDS & Associates, PA

## Consent for Treatment

I hereby authorize the staff and dentists of WNC Dental, J. Randall Latta, DDS & Associates, PA to perform all indicated and agreed upon dental examinations and treatments that have been presented to me. I have been provided with adequate information, in a way I can understand, to make a well-informed and confident decision regarding my proposed treatment. I further understand that I may ask any questions I wish, before, during, and after my treatments.

I am aware dentistry (like medicine), is not an exact science and acknowledge that no guarantees have been made as to the result of any examinations, procedures, or treatments. I further acknowledge that such examinations, procedures or treatments may have unforeseen or unexpected consequences that may result in less than ideal outcomes including complications that produce increased pain, disability, loss of function, morbidity and mortality.

In addition, I understand that in compliance with Federal OSHA (Occupational and Safety Health Administration) procedures, in the event of any exposure to the dentist, staff or patient of blood or other potentially infectious materials, the parties involved shall be deemed to have consented to testing for infectious pathogens to include but not be limited to HIV and Hepatitis and that appropriate follow up will be advised.

I have been given the opportunity to review this office's HIPPA Notice describing how medical and dental information about me may be used and disclosed and how I may get access to this information and I have been offered a copy of this notice.

Understanding the reasonable benefits and risks to the proposed treatments I hereby elect to consent to treatment and release, WNC Dental, J. Randall Latta, DDS & Associates, PA from any liability and waive any and all current or future claims against WNC Dental, J. Randall Latta, DDS & Associates, P A and staff concerning my dental treatments.

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Patient Signature (or Guardian)

Date



**Do you have any history, now or in the past, of any of the conditions listed below (circle each Yes or No)**

Headache/Migraines	Yes or No	Heart disease	Yes or No
Heart Attack	Yes or No	High blood pressure	Yes or No
Asthma	Yes or No	Rheumatic Fever	Yes or No
Anemia	Yes or No	Bladder problems	Yes or No
Bleeding problems	Yes or No	Cancer	Yes or No
Sinus problems	Yes or No	Diabetes	Yes or No
Epilepsy	Yes or No	Fainting	Yes or No
Growth problems	Yes or No	Hearing problems	Yes or No
Hepatitis A, B, or C	Yes or No	HIV+ or AIDS	Yes or No
Liver problems	Yes or No	Low blood pressure	Yes or No
Kidney problems	Yes or No	Seizures	Yes or No
Sickle cell	Yes or No	Tobacco use	Yes or No
Drug abuse	Yes or No	Tuberculosis	Yes or No
Venereal disease or STDs	Yes or No	Allergic reactions	Yes or No
Breathing or lung problems	Yes or No	Osteoporosis	Yes or No
Stomach disease, ulcers	Yes or No	Thyroid disease	Yes or No
Alcoholism	Yes or No	Emotional problems	Yes or No
Stroke	Yes or No	Glaucoma	Yes or No
Arthritis	Yes or No	Pacemaker	Yes or No
Females: Pregnant?	Yes or No	Do you take Blood Thinners? Aspirin?	Yes or No
Females: Nursing?	Yes or No	Females: Take Birth Control Pills?	Yes or No

Females Note: antibiotics can affect the efficacy of oral contraceptives. Additional precautions to avoid pregnancy may be necessary while taking antibiotics and you may need to consult with your physician about this.

Have you ever taken or are taking a bisphosphonate drug like Fosamax, Aredia, Actonel, Boniva, Reclast, Didronel or any drug for bone pain, multiple myeloma, metastatic cancer, osteoporosis or the treatment of Padgett's disease?

Yes No

Do you have any problem, condition, or disease not mentioned above?

Yes No \_\_\_\_\_

**Dental History**

List any problems or concerns you feel you may be having with your-

Teeth \_\_\_\_\_

Gums \_\_\_\_\_

Jaw \_\_\_\_\_

Saliva \_\_\_\_\_

Mouth \_\_\_\_\_

Eating \_\_\_\_\_

What is the main dental reason you are here today? \_\_\_\_\_

Ever had any unusual reaction to dental anesthetic? (numbing) \_\_\_\_\_

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist or his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form and I will inform the doctor and staff immediately of any changes to my health or medications.