

# 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. (Please see our Dental Finance Information sheet.)

### 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) (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

## 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

# WNC Dental

J. Randall Latta, DDS & Associates, PA  
3179 Sweeten Creek Rd Suite 4  
Asheville, NC 28803  
828-684-1288

## Personal Information and Health History

Name \_\_\_\_\_

Address \_\_\_\_\_  
First Middle Last "I like to be called"  
City State Zip

Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Phone \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Email \_\_\_\_\_

Emergency contact: Name \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Dental Insurance Company \_\_\_\_\_ Card Holder's Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ Employer Phone \_\_\_\_\_ Insurance Contact \_\_\_\_\_

### CIRCLE YES or NO

Are you in good health? **Yes No** Any change in your health this past year? \_\_\_\_\_

Are you under the care of a medical doctor? **Yes No** For what condition? \_\_\_\_\_

Have you ever been hospitalized? **Yes No** For what? \_\_\_\_\_

Have you had any serious illness? **Yes No** Describe \_\_\_\_\_

Medications- please list **all medications** you may be taking (including any vitamins or supplements)

\_\_\_\_\_  
\_\_\_\_\_

**Are you allergic** to any medicine, drug, food or other substance? **Yes No**

List: \_\_\_\_\_

Do you have any artificial joints or implants? (hip, knee, pins, screws) **Yes No** \_\_\_\_\_

Do you have any (circle) artificial heart valve, damaged heart transplant, previous endocarditis, or congenital heart disease (CHD) unrepaired cyanotic CHD, completely repaired CHD last 6 months, repaired CHD with residual defects? **Yes No**

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

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

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 Paget'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? \_\_\_\_\_

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.

Signature of Patient (or Guardian)

Date

Fm2010