

**DR. JOHN W. VOLLENWEIDER**

210 North Lewis Street  
LaGrange, Georgia 30240  
(706) 882-2551

www.drvoellenweider.com

**Patient Information**

Date \_\_\_\_\_

Patient's Name \_\_\_\_\_  
 Last First Middle Nickname

Address \_\_\_\_\_  
 Street City State Zip

Home Phone \_\_\_\_\_ Birth date \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**Responsible Party Information**

Name \_\_\_\_\_  
 Last First Middle Marital Status

Residence \_\_\_\_\_  
 Street City State Zip

Mailing Address \_\_\_\_\_  
 Street City State Zip

How long at this address \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birth date \_\_\_\_\_ Work Phone \_\_\_\_\_

**Insurance Information**

Primary Carrier Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_ Group No. \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Do you have dual coverage? Yes  No  If yes: \_\_\_\_\_

Secondary Carrier Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Insurance Co \_\_\_\_\_ Group No. \_\_\_\_\_ Insurance Co. Phone # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

**Emergency Information**

Name of nearest relative not living with you \_\_\_\_\_

Complete Address \_\_\_\_\_

Phone \_\_\_\_\_

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**MEDICAL HISTORY**  
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PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, too often people forget 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 Boniva (R) or Fosamax (R)?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you on a special diet?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use controlled substances?  Yes  No If yes, please explain: \_\_\_\_\_

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  Zithromax  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other Please explain: \_\_\_\_\_

Do you have, or have you had, any of the following? \_\_\_\_\_

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Fainting Spells/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatments	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Heart Pace Maker	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Stomach Problems	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/Fever Blisters	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Hives or Rash	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Intestinal Disease	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
Emphysema	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No
Epilepsy or Seizures	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No		
Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No		

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain. \_\_\_\_\_

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

Do you have an immediate dental problem you are concerned about?  Yes  No \_\_\_\_\_

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When you think about your smile, are you happy with the appearance of you teeth and gums?  Yes  No \_\_\_\_\_

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We sometimes provide digital cosmetic simulations for our patients who are seriously interested in cosmetic changes to their smiles from simple bleaching to full reconstruction at **no charge**. This provices you an opportunity to see the potential in your own smile. Dr. Vollenweider may suggest this for you.

If you could change anything about your smile, what would it be? \_\_\_\_\_

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Are you interested in discussing conscious sedation for your dental treatments?  Yes  No \_\_\_\_\_

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Comments: \_\_\_\_\_

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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 \_\_\_\_\_

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**OFFICE POLICY REGARDING PAYMENT FOR TREATMENT**

Our office feels that it is important for our patients to completely understand their treatment and fees involved. We will provide pretreatment estimates of fees to the best of our ability where desired and appropriate. **Before beginning treatment, a payment plan must be agreed upon by the patient or responsible adult.**

**Fees:**

Fees must be paid in full the day of treatment by cash, check, Visa/Mastercard, Discover or Debit Card **unless prior arrangements have been made.**

A minimum of 25% of the fees charged **plus** deductibles is expected at each treatment visit **when insurance benefits are assigned to Dr. Vollenweider.** If benefits are not assigned, the account must be treated as though there is no insurance and full payment is expected at the time of treatment.

My policy has always been to respect the option my patients have to select their own healthcare provider. Therefore, I never participate in HMO's , PPO's or other plans that restrict a patient's choice of healthcare provider. We know you are here because you choose us. We take that choice very seriously and pledge to continue to work hard to insure your choice is a wise one.

**Insurance:**

Insurance seldom covers the full cost of treatment and some procedures are not covered at all. Patients must remember that professional services are rendered to and charged to the patient, not the insurance company. Even though an insurance claim will be filed, **you remain responsible for the full balance of charges.** This office does not accept the responsibility for collecting insurance claims or for negotiating a settlement or disputed claim. We will file the initial claim for treatment as a courtesy.

I assign my insurance benefits to Dr. John Vollenweider. I understand that this form is valid unless I cancel the authorization through written notice to Dr. Vollenweider. \_\_\_\_\_ (Initial)

**IMPORTANT FACTS ABOUT FINANCIAL ARRANGEMENTS:**

1. Accounts not paid in full will have a service charge of 1.5% per month (18% per year) charged to the account 30 days after treatment on **any** remaining balance **including outstanding insurance claims.**
2. There will be a charge of \$30.00 for each returned check.
3. All delinquent accounts may be subject to additional costs which may include but not be limited to collection fees, court costs and/or attorney's fees. A delinquent account is any account that is not following preapproved financial arrangements.

**A payment method must be chosen:**

- Cash    Check    Insurance
- Visa/Mastercard/Discover (Card number: \_\_\_\_\_ Expiration date: \_\_\_\_\_)
- I authorize Dr. John Vollenweider to keep my signature on file and to charge my Visa/Mastercard/Discover account for:
- Balance of charges not paid by insurance within 60 days and not to exceed \$ \_\_\_\_\_ for:
    - this visit only.
    - all visits this year.
  - Recurring charges (ongoing treatments) of \$ \_\_\_\_\_ every \_\_\_\_\_ from \_\_\_\_\_ to \_\_\_\_\_

Signature for Credit/Debit: \_\_\_\_\_ Date: \_\_\_\_\_

I certify that I have read, agreed to, and received a copy of this Office Policy:

Name (Print): \_\_\_\_\_ Signature: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Social Security Number (SSN): \_\_\_\_\_

Spouse's Name: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

Reviewed By: \_\_\_\_\_ Date: \_\_\_\_\_

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## **Important Facts and Office Policy Regarding Dental Insurance**

Dental Insurance is not to be confused with Medical Insurance. They are two very different products. In the early 1980's dental insurance maximums were generally between \$1000 and \$1500 per year. The cost of living has dramatically changed for all of us since the 1980's; yet still today **in general** the maximum benefit paid by most dental insurance companies is only between \$1000 and \$1500 per year.

Dental Insurance Plans are designed to only **cover a portion of your dental expenses** as evidenced by the practice of only paying a percentage of fees which **they determine themselves**. Even though an insurance plan claims to pay 100%, it may be only of a fee much lower than is generally charged for a procedure or group of procedures.

In regards to fees, you will hear the term "UCR", "usual, customary and reasonable" to determine the level of reimbursement. This "sounds good", but do not be misled by this term. This is often very confusing. You should know that "UCR" often varies with different plans within the same company in the same geographic location. This often is determined by the specific plan you or your employer purchases and when everyone is understandably trying to keep premiums low, often this results in a **lower than desirable "UCR" rate**. Too, these do not seem to be updated as frequently as you might think.

Unfortunately, patients who have extensive restorative and surgical needs trying to spread the needed treatment over multiple plan years may suffer unnecessarily as conditions worsen. We offer third party alternative financing if you have a need or are interested and hopefully wish to complete your treatment in a timely manner that best serves your health needs.

Like medical insurance, dental insurance will often times not cover pre-existing conditions, such as missing teeth. Often these plans do not cover for the more desirable fixed or cemented bridge, but may cover removable appliance.

Most dental insurance plans have exclusions and limitations on frequency of treatments. For instance, cosmetic treatments like bleaching and cosmetic veneers are generally excluded. Periodic examinations, radiographs, "cleanings" and fluoride treatments are often limited by frequency and may even have age limitations. Very few plans cover replacing missing teeth with dental implants at this time. Hopefully that will change one day. Plans vary on these points. It is important to know exactly how your plan coverage on these items works.

It is **not uncommon** for an insurance plan to apply "alternate benefits" for a service. For instance, often insurance plans will not pay for major restorative dentistry like the needed crown or inlay and only pay for "regular" fillings. Also, even though we may agree that a tooth colored restoration is best for you, an insurance plan will often substitute their fees for silver/amalgam fillings.

As a courtesy to our patients, we will gladly file you initial claim at no charge. We do these electronically in most instances which will speed up the process. Refiling claims may be subject to a service charge.

These facts are for general use and information to our patients only and **do not imply a guarantee of insurance coverage nor acceptance of all insurance plans in our office. Patients remain fully responsible for all charges regardless of whether or not the insurance plan pays.**

Finally, please be aware that we are not responsible for tracking your insurance benefits, nor are we responsible for determining your current maximum benefits available at anytime. Please contact your insurance company or your insurance benefits coordinator at your place of employment if you have questions regarding these issues.

### **Insurance Authorization:**

I hereby authorize insurance payment of benefits otherwise payable to me, directly to Dr. John W. Vollenweider. I understand that I am responsible for all costs of dental treatment. I hereby authorize the practice of Dr. John W. Vollenweider, to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information I have provided on my medical and financial history is correct to the best of my knowledge.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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PATIENT ACKNOWLEDGMENT OF  
NOTICE OF PRIVACY PRACTICES

(AS REQUIRED BY THE PRIVACY STANDARDS OF THE HEALTH INSURANCE AND ACCOUNTABILITY ACT OF 1996 HIPPA)

I have been advised of the Notice Of Privacy Practices of **Dr. John W. Vollenweider's** office, on the date indicated below.

I understand that if any changes are made to this Notice Of Privacy Practices, a revised copy will be posted in the office.

I also understand that if I wish to receive copies of this Notice Of Privacy Practices or if I have any questions with regard to this Notice Of Privacy Practices, I may contact the office manager or write to:

HONEY MOMON  
CHIEF PRIVACY OFFICER/COMPLIANCE  
210 NORTH LEWIS STREET  
LAGRANGE, GEORGIA 30240  
1-706-882-2551  
FAX 1-706-845-0469

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Signature of Patient

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Printed Name of Patient

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Date