**Welcome!**

Thank you for choosing our dental healthcare team!  We will strive to provide you with the best possible dental care.

To assist us in meeting all of your dental health needs, please fill out this form completely; using only blue or black ink.

If you have any questions or need assistance with this form, please ask us, we will be happy to help.

**Patient Information**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PATIENT   LAST NAME                            FIRST                           MIDDLE | | | | PREFERRED NAME TO BE CALLED | | | | TODAY’S DATE | |  MALE   FEMALE |
| BIRTH DATE     M.       D      YR | SOCIAL SECURITY NUMBER | HOME PHONE | | | | MARITAL STATUS S   M   D   OTHER | | | | |
| EMAIL | | CELL PHONE | | | | DRIVER'S LICENSE NUMBER | | | | |
| ADDRESS                                                                   APT. OR SPACE NO. | | | CITY | | | | | | STATE | ZIP CODE |
| EMPLOYER   SELF   NONE   RET | | | BUS. PHONE | | | | | | OCCUPATION | |
| BUSINESS ADDRESS                                                   APT. OR SPACE NO. | | | CITY | | | | | | STATE | ZIP CODE |
| EMERGENCY CONTACT                                                                         RELATIONSHIP | | | | | PHONE | | | | | |
| WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?                                                                                                     RELATIONSHIP | | | | | | | | | | |
|  |  |  |  |  |  | |  |  |  |  |

**Responsible Party   SAME AS PATIENT**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| PERSON RESPONSIBLE     LAST NAME                                   FIRST                                        MIDDLE | | | | | | RELATIONSHIP | | | | |
| HOME PHONE | SOCIAL SECURITY NUMBER | | | DRIVER’S LICENSE NUMBER | | | | | | STATE |
| HOME ADDRESS   SAME AS ABOVE | | CITY | | | | | | STATE | ZIP CODE | |
| EMPLOYER   SELF   NONE   RET | BUSINESS ADDRESS | | BUS. PHONE | | | | OCCUPATION | | | |
|  |  |  |  | |  |  |  |  |  |  |

**Insurance Information**

**PRIMARY DENTAL INSURANCE**

|  |  |  |  |
| --- | --- | --- | --- |
| INSURANCE COMPANY NAME | EMPLOYER | | INSURANCE PHONE NO. |
| SUBSCRIBER’S LAST NAME                           FIRST                          MIDDLE | | | SUBSCRIBER’S BIRTH DATE |
| POLICY OR SOC. SEC. NO. | GROUP NO. | RELATIONSHIP OF PATIENT TO SUBSCRIBER SELF   SPOUSE   CHILD   OTHER | |
|  |  |  |  |

**SECONDARY DENTAL INSURANCE**

|  |  |  |  |
| --- | --- | --- | --- |
| INSURANCE COMPANY NAME | EMPLOYER | | INSURANCE PHONE NO. |
| SUBSCRIBER’S LAST NAME                           FIRST                          MIDDLE | | | SUBSCRIBER’S BIRTH DATE |
| POLICY OR SOC. SEC. NO. | GROUP NO. | RELATIONSHIP OF PATIENT TO SUBSCRIBER SELF   SPOUSE   CHILD   OTHER | |
|  |  |  |  |

**Insurance release:** To the extent permitted under applicable law, I hereby authorize release of any information relating to all claim for benefits submitted on behalf of myself and/or my dependants. I hereby assign and authorize payment of dental benefits otherwise payable to me, directly to the office of Lakewood Dental Care. 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 me or my dependants as if I had signed each benefit assignment of future claims.

Patient/Parent/

Guardian Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_

Medical Health Questionnaire

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you under medical treatment now**? **Yes No**

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Have you ever been hospitalized for any surgical operation or serious illness**? **Yes No**

If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Are you taking any medications**? **Yes No**

If yes, please list **all** medications:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Do you now have or have you ever had any of the following?

(Please circle Answer)

**Yes / No** Heart Disease

**Yes / No** Chest Pain

**Yes / No** Blood Pressure Problems

**Yes / No** Heart Murmur

**Yes / No** Heart Valve Problem

**Yes / No** Rheumatic Fever

**Yes / No** Pace Maker

**Yes / No** Stroke

**Yes / No** Abnormal Bleeding

**Yes / No** Leukemia

**Yes / No** Hay Fever

**Yes / No** Sinus Problems

**Yes / No** Skin Rashes

**Yes / No** Asthma

**Yes / No** Intestinal Problems

**Yes / No** Ulcers or Stomach Problems

**Yes / No** Kidney or Bladder Problems

**Yes / No** Joint Replacement

**Yes / No** Back or Neck Pain

**Yes / No** Arthritis

**Yes / No** Fainting, Seizures, Epilepsy

**Yes / No** Frequent or Severe Headaches

**Yes / No** Lupus / Other Auto-immune

**Yes / No** Thyroid Problems

**Yes / No** Multiple Sclerosis

**Yes / No** Persistent Cough / Swollen glands

**Yes / No** Cancer / Tumor

**Yes / No** Diabetes

**Yes / No** Thirsty or Mouth is often dry

**Yes / No** Family History of Diabetes

**Yes / No** Tuberculosis / Respiratory Disease

**Yes / No** Do you smoke or use tobacco?

**Yes / No** Hepatitis, Jaundice, Liver Trouble

**Yes / No** Herpes or Cold Sores

**Yes / No** HIV positive / AIDS

**Yes / No** History of Drug or Alcohol Abuse

# Women

**Yes / No** Are you taking contraceptives or other hormones?

**Yes / No** Are you pregnant?

**Yes / No** Are you nursing?

# Are you allergic or have you ever reacted adversely to any of the following?

**Yes / No** Local anesthetic (“Novocaine”)

**Yes / No** Penicillin or other antibiotics

**Yes / No** Sulfa drugs

**Yes / No** Barbiturates, sedatives, or sleeping pills

**Yes / No** Aspirin, acetaminophen or ibuprofen

**Yes / No** Codeine, Demerol or other narcotics

**Yes / No** Reaction to metals

**Yes / No** Latex or rubber dam

**Yes / No** Other allergies? Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you want complete dental care? **Yes / No**

Are you apprehensive about dental treatment? **Yes / No**

Do you gag easily? **Yes / No**

Do you have difficulty chewing your food**? Yes / No**

Do your gums bleed easily? **Yes / No**

Are your teeth sensitive? **Yes / No**

Are you dissatisfied with the appearance of your teeth? **Yes / No**

Do you prefer to save your teeth? **Yes / No**

## Do you clench or grind your teeth frequently? Yes / No

Do you have any jaw symptoms or headache upon awakening in the morning? **Yes / No**

Do you have temporomandibular (jaw) disorder? (Such as TMD or TMJ)? **Yes / No**

Do you have pain in the face, cheeks, jaws, joints, throat or temples? **Yes / No**

Have you had a blow to the jaw (trauma)? **Yes / No**

**Patient (Parent/Legal guardian) Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**: \_\_\_\_\_\_\_\_\_\_\_\_ Dr/Hyg Initials\_\_\_\_\_\_\_

**UPDATE**: I have reviewed my medical history and made any changes:

1. Date:\_\_\_\_\_\_\_\_\_ Patient Initials\_\_\_\_\_\_\_\_ Dr/Hyg Initials\_\_\_\_\_\_\_

UPDATE COMMENTS:

1. Date:\_\_\_\_\_\_\_\_\_\_\_ Patient Initials\_\_\_\_\_\_\_\_ Dr.’s Initials\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_ Patient Initials\_\_\_\_\_\_\_\_ Dr/Hyg Initials\_\_\_\_\_\_\_

Date:\_\_\_\_\_\_\_\_\_\_\_ Patient Initials\_\_\_\_\_\_\_\_ Dr/Hyg Initials\_\_\_\_\_\_\_

*A family dental practice committed to wellness*

Welcome to our dental office! Our goal and commitment is to provide our patients with the highest quality dental care through education, prevention and treatment in a pleasant and comfortable environment. Good communication is the key to quality care and we invite your questions. Please take a few minutes to read the following information and familiarize yourself with our office.

**Payment at the time of service**

We require payment at the time of service. For your convenience we accept Visa, MasterCard, Discover, Personal Checks and Cash. Also offered is an interest free and low monthly payment option through Care Credit™, a third party lending company. We are happy to assist you with any of these payment plan options, please ask us!

We also offer a 5% cash/check discount to all who pay in full by cash or check on the day of service.\* For our senior citizens age 62 or older there is an additional 5% discount!\*

**\*These options are only for those patients who do not have PPO Dental Benefits**

**Insurance and Insurance Co-Payment Responsibility**

Full payment of your account is your responsibility. We will file your insurance claims on your behalf as a courtesy to you, provided your dental insurance company will assign benefits directly to us. Having dental insurance is not a guarantee of payment. Your insurance coverage is a contract that is set up between your employer and the insurance company. We can only guarantee our fees and **ESTIMATE** your dental benefits. We ask that you review all estimates and call your insurance company with any questions.

If you have dental insurance, we will ask you to make your copayment at the time of service. Your copayment is the dollar amount that is estimated as not payable by your dental insurance plan. If payment for completed treatment is not paid by your dental insurance company with 90 days, we reserve the right to request payment in full for the balance owing on your account. When your insurance carrier eventually pays, we will gladly refund the difference to you.

**Returned Check Fee**

All patients paying for balances via personal check will be responsible for an additional fee of $35 on checks returned from the bank for Non Sufficient Funds as well as stop payment issued on a check payment or credit card payment.

**Finance Charges**

Finance charges accrue on the unpaid balance beginning on the 60th day after charges are incurred. The interest rate will be 12% per annum or the maximum allowable according to state law. In the event that the account is referred to collections, the undersigned, or the agent, will be responsible for payment of interest on the unpaid balance at 1% per month from the date of service, in addition to collection fees, reasonable attorney fees and court cost.

**Broken Appointment Fee**

We request 48 hours notice to change an appointment. A charge may be applied to your account in the amount of $50 per hour if an appointment is changed with less than 48 hours notice, or if you fail to keep your scheduled appointment.

*I hereby acknowledge receipt of the above information and understand that I am completely responsible for the total payment of all procedures performed.*

Printed Name Signed Name Date

**STATEMENT OF PRIVACY PRACTICES**

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes.

* **Protecting your personal Health Information**

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone-even family members-without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

* **Collecting Protected Health Information**

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment date, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

* **Disclosure of your Protected Health Information**

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments through voicemail messages, answering machines and postcards.

* **Patient Rights**

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient in our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

\*\*You may refuse to sign this acknowledgement\*\*

I, , have received a copy of this office’s Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

* + Individual refused to sign
  + Communications barrier prohibited obtaining the acknowledgement
  + An emergency situation prevented us from obtaining acknowledgement
  + Other (Please Specify)

**Authorization to Leave Personal Health Information**

**By Alternate Means**

Patient Name: Date of Birth:

Patient Mailing Address:

(Please check all that apply)

May leave detailed message on voicemail at home #: ( )

May leave detailed message on voicemail at work #: ( )

May leave detailed information with spouse/other family member(name):

May leave detailed message on cellular phone #: ( )

May send detailed message by email to:

With my signature below, I acknowledge and understand that this information will be kept in my medical record and the above parameters will be abided by until revoked by me in writing. It is my responsibility to notify my healthcare provider should I change one or more of the telephone numbers listed above.

Patient or legally authorized individual signature Date