Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, do not hesitate to ask.

Patient name: ______________________________________ Date of birth: ________________ Sex: _______ Age: _________

Home address: _____________________________________ City: _______________________ State: ______ Zip:__________

Billing address (if different): __________________________ City: _______________________ State: ______ Zip:__________

Home phone: ______________________ Cell: _____________________________ E-mail: ____________________________

Would you prefer an email or text reminder for appointments? ___________ Wireless provider: __________________________

Employer/Occupation: ____ Bus. Phone: _________________________________

Spouse's name & phone #: ____ Occupation:________________________________

Emergency name (other than spouse): ________________________________ Phone #:____________________________________

Primary dental insurance: ____ Group #:____________________

Secondary dental insurance: ____ Group #:____________________

Subscriber's name: __________________________________ Date of birth:_____________ SS #:_______________________

Name and # of your medical doctor: ____ Last visit: ___________________

Name of previous dentist: ____ Last visit: ___________________

How did you hear about our office: ____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Have you ever noticed cold sores in or about your mouth?	☐	☐

	Yes	No
Do your gums bleed easily	☐	☐
Are your teeth sensitive?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Would you like your teeth to be whiter?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐
How often do you brush? _________________		
How often do you floss? __________________		
Do you use other aids?	☐	☐
Do you have any history of jaw discomfort?	☐	☐

MEDICAL HEALTH HISTORY:
Do you have, or have you had, any of the following?

	Yes	No
Heart Problems	☐	☐
Chest pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement	☐	☐
Osteoporosis	☐	☐
Medication required?	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Medication required?	☐	☐
Thyroid problems	☐	☐
Medication required?	☐	☐
Persistent cough or swollen glands	☐	☐
Diabetes	☐	☐
Thirsty or frequent dry mouth	☐	☐
Family history of diabetes	☐	☐
Glaucoma	☐	☐
Hepatitis, jaundice or liver trouble	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Cancer/Tumor	☐	☐

Treatment history: ____________________

	Yes	No
Allergy Problems	☐	☐
Sinus problems	☐	☐
Taking allergy medications	☐	☐
Asthma	☐	☐
Do you consume alcohol?	☐	☐
Do you use tobacco?	☐	☐
History of cold sores or herpes	☐	☐
HIV-positive	☐	☐
Do you wear contact lenses?	☐	☐
History of alcohol or drug abuse?	☐	☐
Premedication required by physician	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: _________________________________

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics (“Novocaine”)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other:____

Current medication list and reason you are taking:

____

____

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you or could you be pregnant?	☐	☐

If so, expected due date: ___________

Print Name: _______________________________________

Patient Signature: __________________________________

Dentist Initial: _____________________________________

Financial Policy

Insured Patients

Patients with insurance are asked to pay the deductible and estimated patient portion at the time of service. We are more than happy to file your insurance claim for you. Please keep in mind the estimated portion is just that, an estimate. Filing insurance claims is a courtesy we extend to our patients. We make every effort to follow up on unpaid claims, however, if we have not received payment after 60 days we ask you to discuss your claim with your insurance company.

Non-Insured Patients

If you do not have dental insurance we ask for payment in full at the time of service. If you feel financial arrangements are necessary you may discuss this with the front office staff before treatment is started.

Usual and Customary Rate (UCR)

Our practice is committed to providing the best treatment possible for our patients. Our fees reflect the usual and customary rates for our area. Keep in mind the rates paid by your insurance carrier are determined by the insurance carrier and your employer and in some situations have no bearing on the real usual and customary rates charged in the local area.

No-Show and Cancellation Policy

Your visit has been reserved especially for you. If you are unable to keep your appointment we require 48 hours notice for cancelling/re-scheduling. If 48 hour notice is not provided we reserve the right to apply a late cancellation fee of $100.00.

Divorces

Both partners are responsible for the debts incurred up to the date of the divorce decree. The parent who requests treatment for a child is responsible for the balance of services rendered.

Late and Finance Charges

A finance charge will be imposed on those charges not paid in full within 90 days of the day treatment was rendered. The finance charge is a periodic rate of 1.5% per month (18% annually). The amount of the late charge will be as authorized under the laws of Washington, with a minimum charge of $1.00.

Emergencies

Should you experience a dental emergency after hours, please call our office. The recorded phone message will provide an emergency contact number.

Statement of Understanding

Patient Name:____
Signature:____Date:________________________
Parent or Guardian if Patient is a Minor