



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?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had problems with previous dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>
Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty in chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed cold sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Do your gums bleed easily	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive?	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Would you like your teeth to be whiter?	<input type="checkbox"/>	<input type="checkbox"/>
Do you prefer to save your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
Do you want complete dental care?	<input type="checkbox"/>	<input type="checkbox"/>
How often do you brush? _____		
How often do you floss? _____		
Do you use other aids?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any history of jaw discomfort?	<input type="checkbox"/>	<input type="checkbox"/>

MEDICAL HEALTH HISTORY:

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

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

	Yes	No
Allergy Problems	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medications	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>
Do you consume alcohol?	<input type="checkbox"/>	<input type="checkbox"/>
Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>
History of cold sores or herpes	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse?	<input type="checkbox"/>	<input type="checkbox"/>
Premedication required by physician	<input type="checkbox"/>	<input type="checkbox"/>
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")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____		

Current medication list and reason you are taking:

Women

	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you or could you be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
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 for you, if you are unable to keep your appointment we require 48 hours notice for cancelling/re-scheduling. If 48 hours is not provided a late cancellation fee of \$100.00 could be applied to your account.

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



ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Banner Family Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practice is also posted in the facility.

Banner Family Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

- | | | |
|-----------------------------------|------------------------------|-----------------------------|
| ANY MEMBER OF MY IMMEDIATE FAMILY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| SPOUSE ONLY | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| MESSAGE ON WORK TELEPHONE: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| MESSAGE ON HOME/CELL TELEPHONE: | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| OTHER (please specify): _____ | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICIAL USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Provided Prior to Treatment?	<input type="checkbox"/> YES <input type="checkbox"/> NO
Date Provided:	_____
Reason for Denial:	<input type="checkbox"/> Needed more time to review statement of privacy practices. <input type="checkbox"/> Wanted to consult with another person, before signing. <input type="checkbox"/> Unable to sign. <input type="checkbox"/> Reason not given. <input type="checkbox"/> Other (Explain): _____

Please turn page over to fill out additional side