

Patient Name: \_\_\_\_\_  
 Last First MI (Preferred name) Date  
 Birthdate: \_\_\_\_\_ Gender: Male  Female  Married \_\_\_ Single \_\_\_ Other \_\_\_ Child \_\_\_  
 Phone (Home): \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Social Security # \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Work phone Number: \_\_\_\_\_ Ext: \_\_\_\_\_ May we call you at work? Yes  No   
 Who will be responsible for your account? Self: \_\_\_ Spouse: \_\_\_ Mother: \_\_\_ Father: \_\_\_ Other: \_\_\_  
 Nearest Relative not living with you: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Who referred you to our office? \_\_\_\_\_  
 Student? Yes  No  If yes Full time: \_\_\_ Part time: \_\_\_ School Name: \_\_\_\_\_ City: \_\_\_\_\_

**Spouse or Responsible Party Information**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Male  Female  Last First MI  
 Social Security #: \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Street Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Phone (Home): \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
 Work Phone: \_\_\_\_\_ Ext. \_\_\_\_\_

**Insurance Information**

|                                 |                                   |
|---------------------------------|-----------------------------------|
| <b>Primary Dental Insurance</b> | <b>Secondary Dental Insurance</b> |
| Insurance Co.: _____            | Insurance Co.: _____              |
| Address: _____                  | Address: _____                    |
| Phone: _____                    | Phone: _____                      |
| Name of Insured: _____          | Name of Insured: _____            |
| Phone: _____                    | Phone: _____                      |
| SS#: _____                      | SS#: _____                        |
| Employer: _____                 | Employer: _____                   |
| Relation to Patient: _____      | Relation to Patient: _____        |

I authorize treatment of the person named in "Patient Information" above. I agree that I am responsible for all fees incurred for dental treatment rendered for the above patient, regardless of dental insurance benefits. I will make any estimated payment/co-payment at the time of service and I authorize the dentist to bill my insurance company on my behalf. I understand that any estimate provided to me is NOT a guarantee of treatment and/or payment, as dental insurance contracts vary widely from employer to employer and carrier to carrier. If my account becomes delinquent, I agree to pay all reasonable fees related to collecting the balance on my account.

Washington State law allows me to ask to see a copy of my dental records, if I make a written request to my health care provider. As your health care provider, we will not disclose your dental records to others unless the law authorizes or compels us to do so.

I certify that the above information is true and that if I am signing for a minor child, I have the legal authority to seek dental care for my dependent.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\_\_\_\_\_  
 Signature of Account Guarantor (Must be over 18) Date: \_\_\_\_\_

## Health History Information

Name: \_\_\_\_\_

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

Name of Physician \_\_\_\_\_

Phone: \_\_\_\_\_

Are you currently under the care of a physician? Yes  No  Date of last physical? \_\_\_\_\_

Have there been any changes to your general health or have you been hospitalized in the last year?

Yes  No  If yes please explain: \_\_\_\_\_

|  | YES                      | NO                       |  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Heart Problems   | <input type="checkbox"/> | <input type="checkbox"/> | Fainting Spells, seizures, or Epilepsy   | <input type="checkbox"/> | <input type="checkbox"/> |
| Chest pain   | <input type="checkbox"/> | <input type="checkbox"/> | Stroke(s)  | <input type="checkbox"/> | <input type="checkbox"/> |
| Shortness of breath                                      | <input type="checkbox"/> | <input type="checkbox"/> | Frequent or severe headaches   | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood pressure problems                                  | <input type="checkbox"/> | <input type="checkbox"/> | Thyroid Problems   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart murmur   | <input type="checkbox"/> | <input type="checkbox"/> | Persistent cough or swollen glands   | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart valve problem                                      | <input type="checkbox"/> | <input type="checkbox"/> | Cancers or Tumor   | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking heart medication                                  | <input type="checkbox"/> | <input type="checkbox"/> | Premedication required by a physician  | <input type="checkbox"/> | <input type="checkbox"/> |
| Rheumatic fever  | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis, jaundice, or liver trouble  | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker  | <input type="checkbox"/> | <input type="checkbox"/> | Herpes or other STD  | <input type="checkbox"/> | <input type="checkbox"/> |
| Artificial heart valve                                   | <input type="checkbox"/> | <input type="checkbox"/> | HIV-positive/AIDS  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood Problems   | <input type="checkbox"/> | <input type="checkbox"/> | Glaucoma   | <input type="checkbox"/> | <input type="checkbox"/> |
| Easy bruising  | <input type="checkbox"/> | <input type="checkbox"/> | Do you wear contact lenses?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent nosebleeds                                      | <input type="checkbox"/> | <input type="checkbox"/> | History of head injury?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Blood disease (anemia)                                   | <input type="checkbox"/> | <input type="checkbox"/> | Epilepsy or other neurological disease?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Ever require a blood transfusion                         | <input type="checkbox"/> | <input type="checkbox"/> | Do you drink alcohol?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Allergy Problems   | <input type="checkbox"/> | <input type="checkbox"/> | If so how much? _____  |                          |                          |
| Hay fever  | <input type="checkbox"/> | <input type="checkbox"/> | Do you smoke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Sinus problems   | <input type="checkbox"/> | <input type="checkbox"/> | If so how much? _____  |                          |                          |
| Skin rashes  | <input type="checkbox"/> | <input type="checkbox"/> | History of drug or alcohol abuse?  | <input type="checkbox"/> | <input type="checkbox"/> |
| Taking allergy medication                                | <input type="checkbox"/> | <input type="checkbox"/> | Do you have any disease, condition or<br>problem not listed that you feel we<br>should know about? | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma   | <input type="checkbox"/> | <input type="checkbox"/> | If so please describe? _____   |                          |                          |
| 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"/> |  |                          |                          |
| Special diet   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Constipation or diarrhea                                 | <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<br>(e.g., total hip, pins or implants) | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Diabetes   | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Urinate more than 6 times a day                          | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Thirsty or mouth is dry most of the time                 | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |
| Family history of diabetes                               | <input type="checkbox"/> | <input type="checkbox"/> |  |                          |                          |

**Continued other side**

|  | YES                      | NO                       | Women  | YES                      | NO                       |
|--|--------------------------|--------------------------|--|--------------------------|--------------------------|
| Are you allergic, or have reacted adversely to any of the following? |                          |                          | Are you taking contraceptives or other hormones? | <input type="checkbox"/> | <input type="checkbox"/> |
| Local anesthetics ("Novocain")                                       | <input type="checkbox"/> | <input type="checkbox"/> | Are you pregnant?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Penicillin or other antibiotics                                      | <input type="checkbox"/> | <input type="checkbox"/> | If so, expected delivery date:                   |                          |                          |
| Sulfa drugs  | <input type="checkbox"/> | <input type="checkbox"/> | Are you nursing?                                 | <input type="checkbox"/> | <input type="checkbox"/> |
| Barbiturates, sedatives or sleeping pills                            | <input type="checkbox"/> | <input type="checkbox"/> | Have you reached                                 |                          |                          |
| Aspirin, Acetaminophen, or Ibuprophen                                | <input type="checkbox"/> | <input type="checkbox"/> | menopause?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Codeine, Demerol, or other narcotics                                 | <input type="checkbox"/> | <input type="checkbox"/> | If so, do you have any                           |                          |                          |
| Reaction to metals   | <input type="checkbox"/> | <input type="checkbox"/> | symptoms? _____                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Latex or rubber dam  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |                          |                          |
| Other _____  |                          |                          | _____  |                          |                          |

| During the past 12 months, have you taken any of the following? | YES                      | NO                       | Please list all OTC and/or prescription medications that you are taking: |
|---|--------------------------|--------------------------|--|
| Antibiotics or sulfa drugs                                      | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Anticoagulants (e.g., Coumadin)                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| High blood pressure medicine                                    | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Tranquilizers   | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Insulin, Ornase or similar drug                                 | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Aspirin   | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Digitalis or drug for heart trouble                             | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Nitroglycerine  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Cortisone (steroids)  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Natural remedies  | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Nonprescription drugs/supplements                               | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| Other _____   | <input type="checkbox"/> | <input type="checkbox"/> | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |
| _____   |                          |                          | _____  |

To the best of my knowledge, all of the above information is true and correct. If I ever have any change in my health or medication, I will inform Dr. Herbert Todd at the next appointment.

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

Relationship to patient: \_\_\_\_\_

### Dental History Information

**Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Previous Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

How often do you brush your teeth? \_\_\_\_\_ Floss? \_\_\_\_\_

What other aids do you use to clean your teeth? \_\_\_\_\_

|   | Yes | No |
|---|-----|----|
| Do your gums ever bleed?  |     |    |
| Do you experience bad breath or unpleasant tastes?                              |     |    |
| Have you ever been diagnosed with periodontal disease?                          |     |    |
| Did you receive treatment for this?   |     |    |
| Do you breath through your mouth during the day or night?                       |     |    |
| Are your teeth sensitive to cold, heat, sweets or pressure?                     |     |    |
| Do you grind or clench your teeth?      Day or Night?                           |     |    |
| Do your jaws pop, click, ache or feel tired?                                    |     |    |
| TMJ fatigue or pain?  |     |    |
| Have you ever had an injury to your face , neck or jaw?                         |     |    |
| Do you have headaches or excessive tension across your forehead or temple area? |     |    |
| Have you ever had orthodontic treatment?  |     |    |
| Do you smoke or chew tobacco?   |     |    |
| Have you have problems with snoring or Sleep Apnea?                             |     |    |
| Have you ever had an unfavorable dental experience?                             |     |    |
| Are you dissatisfied with the appearance of your teeth?                         |     |    |

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Parent or Guardian:** \_\_\_\_\_

**Date:** \_\_\_\_\_

## FINANCIAL POLICY

The best dentistry is based on mutual understanding. In order to prevent any misunderstanding about finances, the following credit arrangements are available:

1. Payment or Co-payment is due at the time of service. Co-pay is the percent your insurance company will not cover plus any annual deductible.
  - 10% senior citizen discount for patients 62 years or older, without dental insurance.

OR

  - 5% cash discount for patients paying at the time of service, without dental insurance.
2. We accept Visa, MasterCard and Discover credit cards.
3. We offer two options for payment plans upon approval of credit:
  - **Wells Fargo**, which offers 3 or 6 months deferred interest financing.
  - **Care Credit**, which offers 3, 6 or 12 months deferred interest financing, depending upon the amount of treatment financed. An Extended Plan is available thru Care Credit for treatment totaling \$1500 or greater.

## DENTAL INSURANCE

We are happy to cooperate with patients who have dental insurance. We will bill your insurance company for treatment rendered. We ask you to pay your estimated co-payment at the time treatment is rendered.

Insurance estimates quoted by our office are estimates based upon your plan coverage and are NOT a guarantee of payment. Reimbursement is determined by your insurance carrier when claims are processed. Any change in your treatment plan either by your choice or by necessity will change the fees quoted.

We ask that you read your policy and be fully aware of any limitations of the benefits provided. We will gladly help you with any questions you may have. Your insurance company agreement is between you and your insurance carrier, therefore, it is to your benefit to understand all aspects of your dental plan. You are ultimately responsible for payment of all services rendered to you and any family members covered by your insurance policy, should your insurance company fail to reimburse our office.

## APPOINTMENTS

So that we can provide you with optimal care in the time scheduled, please be on time for your appointment.

If you are unable to make an appointment, we respectfully request that you give us 48 hours notice. We reserve the right to charge for broken appts without 48 hrs notice that we are unable to fill.

I have read and agree to the above policies of this office.

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

**ACKNOWLEDGEMENT  
OF  
PRIVACY PRACTICES**

Herbert E. Todd, DDS  
4445 Lacey Blvd. SE  
Lacey, WA 98503  
(360) 491-2532

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Relationship to Patient: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_

**Additional Disclosure Authority**

I authorize Herbert E Todd DDS, PLLC to discuss my Treatment and billing with:

- Entire immediate family
- Spouse only
- Other/none

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**For Office Use Only:**

☛ We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other