Herbert E. Todd, DDS PLLC
Family Dentistry

4445 Lacey Blvd. SE * Lacey, WA 98503
360-491-2532 * Fax: 360-923-9565

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

Primary Dental Insurance

Insurance Co.: ____________
Address: ____________
Phone: ____________
Name of Insured: ____________
Phone: ____________
SS#: ____________
Employer: ____________
Relation to Patient: ____________

Secondary Dental Insurance

Insurance Co.: ____________
Address: ____________
Phone: ____________
Name of Insured: ____________
Phone: ____________
SS#: ____________
Employer: ____________
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, irregardless 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: ____________

______________________________ Date: ____________
Signature of Account Guarantor (Must be over 18)

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	☐	☐	Fainting Spells, seizures, or Epilepsy	☐	☐
Chest pain	☐	☐			
Shortness of breath	☐	☐	Stroke(s)	☐	☐
Blood pressure problems	☐	☐			
Heart murmur	☐	☐	Frequent or severe headaches	☐	☐
Heart valve problem	☐	☐			
Taking heart medication	☐	☐	Thyroid Problems	☐	☐
Rheumatic fever	☐	☐			
Pacemaker	☐	☐	Persistent cough or swollen glands	☐	☐
Artificial heart valve	☐	☐			
			Cancers or Tumor	☐	☐
Blood Problems	☐	☐			
Easy bruising	☐	☐	Premedication required by a physician	☐	☐
Frequent nosebleeds	☐	☐			
Blood disease (anemia)	☐	☐	Hepatitis, jaundice, or liver trouble	☐	☐
Ever require a blood transfusion	☐	☐			
			Herpes or other STD	☐	☐
Allergy Problems	☐	☐			
Hay fever	☐	☐	HIV-positive/AIDS	☐	☐
Sinus problems	☐	☐			
Skin rashes	☐	☐	Glaucoma	☐	☐
Taking allergy medication	☐	☐	Do you wear contact lenses?	☐	☐
Asthma	☐	☐			
			History of head injury?	☐	☐
Intestinal Problems	☐	☐			
Ulcers	☐	☐	Epilepsy or other neurological disease?	☐	☐
Weight gain or loss	☐	☐			
Special diet	☐	☐	Do you drink alcohol?	☐	☐
Constipation or diarrhea	☐	☐	If so how much?____________		
Kidney or bladder problems	☐	☐			
			Do you smoke?	☐	☐
Bone or Joint Problems	☐	☐	If so how much?____________		
Arthritis	☐	☐			
Back or neck pain	☐	☐	History of drug or alcohol abuse?	☐	☐
Joint replacement	☐	☐			
(e.g., total hip, pins or implants)			Do you have any disease, condition or problem not listed that you feel we		
Diabetes	☐	☐	should know about?	☐	☐
Urinate more than 6 times a day	☐	☐	If so please describe?____________		
Thirsty or mouth is dry most of the time	☐	☐	____________		
Family history of diabetes	☐	☐	____________		

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?	☐	☐
Local anesthetics ("Novocain")	☐	☐	Are you pregnant?	☐	☐
Penicillin or other antibiotics	☐	☐	If so, expected delivery date:		
Sulfa drugs	☐	☐	Are you nursing?	☐	☐
Barbiturates, sedatives or sleeping pills	☐	☐	Have you reached		
Aspirin, Acetaminophen, or Ibuprophen	☐	☐	menopause?	☐	☐
Codeine, Demerol, or other narcotics	☐	☐	If so, do you have any		
Reaction to metals	☐	☐	symptoms?____________	☐	☐
Latex or rubber dam	☐	☐	____________________		
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	☐	☐	____________________
Anticoagulants (e.g., Coumadin)	☐	☐	____________________
High blood pressure medicine	☐	☐	____________________
Tranquilizers	☐	☐	____________________
Insulin, Ornase or similar drug	☐	☐	____________________
Aspirin	☐	☐	____________________
Digitalis or drug for heart trouble	☐	☐	____________________
Nitroglycerine	☐	☐	____________________
Cortisone (steroids)	☐	☐	____________________
Natural remedies	☐	☐	____________________
Nonprescription drugs/supplements	☐	☐	____________________
Other____________________	☐	☐	____________________

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 PRACICES

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

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