Patient Information

Patient's Name: _____ Birthdate: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____

If patient is a minor, parent or guardian's name: _____

Address: _____
Street Apartment #

_____ How long at this address?_____
City State Zip Code

Phone (Home): _____ (Work): _____ Ext: _____ (Cellular): _____

Email address: _____May we send email appointment reminders?_____

Social Security Number_____ Driver's License Number_____

Employer Name: _____ Occupation: _____

Address: _____
Street Phone #

_____ How long at this employer?_____
City State Zip Code

Spouse's Name_____ Birthdate_____

Employer Name: _____ Occupation: _____

Address: _____
Street Phone #

_____ How long at this employer?_____

Insurance Company Name and Address_____

_____

Subscriber Social Security Number_____ Birthdate_____Group Number_____

Do you have additional dental insurance?_____ Subscriber Name_____

Subscriber Social Security Number_____ Birthdate_____Group Number_____

Secondary Insurance Company Name and Address _____

_____

Please let us know how you heard about our office: _____

Nearest relative not residing with you_____Relationship_____

Address:_____Phone _____

Emergency contact: (someone other than responsible party) _____

Address:_____Phone _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

HEALTH HISTORY

Name _____ Date _____

Date of last health care exam: _____ What was this exam for? _____

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

1. _____
2. _____
3. _____
4. _____

For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

Anemia or Blood Disorder?	No	Yes	Hepatitis, Any Form	No	Yes
Arthritis, Rheumatism or other inflammatory disease?	No	Yes	Joint Replacement? When placed?	No	Yes
Asthma	No	Yes	Kidney Disease	No	Yes
Abnormal Bleeding from a cut?	No	Yes	Liver Disease (including Jaundice)	No	Yes
Cancer or Tumor?	No	Yes	Sore/Enlarged Lymph Nodes	No	Yes
Diabetes	No	Yes	Psychosis / Depression / Bipolar	No	Yes
Emphysema or other Respiratory/Lung Illnesses	No	Yes	Previous Biopsies	No	Yes
Epilepsy	No	Yes	Radiation or Chemotherapy Treatment	No	Yes
Fainting or Dizzy Spells	No	Yes	Rheumatic Fever	No	Yes
Glaucoma (Wide angle or Narrow angle?)	No	Yes	Slow-Healing Mouth Sores	No	Yes
Abnormal Heart or Previous Bacterial Endocarditis	No	Yes	Unintentional Weight Loss/Gain	No	Yes
Heart Valve (artificial) or Heart Transplant	No	Yes	H.I.V. Infection/AIDS or ARC	No	Yes
Congenital Heart Disease	No	Yes	Venereal Disease (sexually Transmitted Disease)	No	Yes
Heart Disease, Heart Attack, Heart Surgery	No	Yes	Other Conditions	No	Yes
Heart Stent? When placed?	No	Yes	Recurrent Illnesses	No	Yes

ANY OTHER CONDITION NOT LISTED: _____

Are you taking any of these medications?

Pre-medication before dental treatment?	No	Yes	Tagamet® (cimetidine) or Prilosec® (omeprazole)?	No	Yes
Antacids? (Tums, Rolaids, Etc.)	No	Yes	Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)?	No	Yes
Dilantin® or Tegretol®	No	Yes	Serzone® (nefazodone)	No	Yes
Barbiturates (any) (Seconal, Brevital, Etc.)	No	Yes	Diflucan® (fluconazole) or Sporonox® (itraconazole)	No	Yes
St. John's Wort or Kava-Kava?	No	Yes	Biaxin® (clarithromycin)	No	Yes
Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? If so, when did the treatment begin? When did the treatment end?				No	Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss?				No	Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract?				No	Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

© 2009 NPP, LLC All Rights Reserved

Please list any dietary or herbal supplements you are taking, and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Women: Are you pregnant?	No	Yes
If no, are you planning a pregnancy in the near future?	No	Yes
Are you a nursing mother?	No	Yes
Are you taking birth control pills?	No	Yes
Abnormal Blood Pressure? (Please circle)	No	Yes

Have you ever received a diagnosis of "high blood pressure"?

What is your normal blood pressure? S /D Today: _____/_____

Are you allergic or have you had a reaction to:

a.	Local anesthetics	No	Yes
b.	Penicillin or other antibiotics	No	Yes
c.	Aspirin, Ibuprofen or Tylenol	No	Yes
d.	Codeine, Valium® or other sedatives.....	No	Yes
e.	Latex or Metals		
f.	Sulfites (Red wine, PABA in sunscreen, Food in salad bar?)		
g.	Other (please specify)_____		

Tobacco, Alcohol, Drugs

Do you use tobacco? If yes, circle type: smoke chew How much per day? For how long?	No	Yes
Do you want to quit using tobacco?	No	Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week?	No	Yes
Do you use any mood altering drugs other than those previously listed? (CONFIDENTIAL & MAY BE LIFE THREATENING WITH DENTAL ANESTHETIC.)	No	Yes

Weight and Diet considerations

Weight	Meals per Day	Dietary Restrictions	Food Allergies
Sugar in your diet (circle one): *none slight moderate high*			

DOCTOR'S USE ONLY

Comments on patient interview concerning medical history:

_____

_____

Significant findings from questionnaire or oral interview:

_____

_____

Dental management considerations:

_____

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.

_____ _____ _____

Patient (Print Name) *Patient Signature* *Date*

_____ _____ _____

Doctor (Print Name) *Doctor Signature* *Date*

© 2009 NPP, LLC All Rights Reserved

Dental Information- Comprehensive Exam

Reason for today's visit _____

Date of last dental appointment: _____ Dentist Name: _____

Date of last dental x-rays: _____

Have you ever had any of the following? Please check those that apply:

- ☐ Bad Breath
- ☐ Bad dental experience
- ☐ Burning sensation on tongue
- ☐ Broken fillings
- ☐ Chew on only one side of mouth
- ☐ Clicking, popping or locking of jaw
- ☐ Difficult Extractions
- ☐ Dry Mouth
- ☐ Food collection between teeth
- ☐ Grinding/Clenching
- ☐ Gums swollen or tender
- ☐ Headaches
- ☐ Jaw pain or tiredness
- ☐ Loose teeth
- ☐ Mouth Breathing
- ☐ Orthodontic Treatment
- ☐ Pain around ear
- ☐ Periodontal Therapy/ or Deep Cleaning
- ☐ Pierced Tongue
- ☐ Reaction to anesthesic
- ☐ Sensitivity to cold
- ☐ Sensitivity to heat
- ☐ Sensitivity to sweets
- ☐ Sores or growths in mouth

Habits:

- ☐ Gum chewing
- ☐ Mint/Hard Candy use
- ☐ Tobacco Use
  - -Cigarettes
  - -Pipe
  - -Chew
  - -Patch
  - -Other

How often do you brush? _____ How often do you floss? _____

Are you happy with your smile? What would you like to see changed, if anything? _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____

Signature of patient, parent or guardian

ALL SMILES
DENTISTRY

FINANCIAL & APPOINTMENT POLICY

We are committed to providing you with the best possible care and to a trusting partnership with you in your dental care. Your clear understanding of our Financial and Appointment Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial and Appointment Policy, or your responsibility at any time.

Your Payment is due at the time of treatment

Payment for treatment is due at the time services are rendered. Prepayment for all laboratory fabricated dental treatment is required (crowns, onlays, bridges, dentures, etc.). We accept most major credit cards, personal check, money order or cash. If you prefer a deferred payment option we offer Care Credit and Chase, simply ask for a short application and/or apply online.

Dental Benefits (Insurance) – We go the extra mile

If you have dental benefits, we will make a good faith estimate of our benefits and defer billing you for that amount for up to 60 days. As a courtesy to you, we will file the appropriate claim forms with your dental benefit company. We will also track your dental claims, follow-up with your benefit provider when claims are not processed in a timely manner and attempt to expedite payment. We are also happy to provide your benefit carrier with x-rays or other information they may require in accordance with the Health Insurance Portability & Accountability Act (HIPAA).

If your dental benefit carrier denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your benefits carrier and/or your employer and your benefits provider. We will make every attempt to assist you in obtaining any benefits due you by your dental benefit provider.

For all Patients: Please help us to serve you, and our other patients, by keeping your scheduled appointments. We do require at least 48 HOURS NOTICE for any schedule changes to avoid an appointment charge. To help compensate the cost of lost appointments, there will be a broken appointment charge of $50.00 per each half hour of scheduled time.

I understand that any delinquent balances are subject to a Finance Charge of 1% every month until balance is paid in full. Regardless of dental benefit coverage, I am responsible for the entire fee for any treatment rendered and any related expenses. I understand that I am responsible to pay reasonable attorney's fees and collection expenses incurred and expended in the event should my account be referred to an attorney or agency for collection.

Assignment and release: I authorize payment to be made directly to the dentist by my dental benefit company. I accept financial responsibility for all services whether covered or not by my dental benefits provider and I authorize release of any dental or medical care information requested by my benefit carrier.

Thank you for understanding our Financial & Appointment Policy. Please let us know if you have any questions.

Patient Signature Date

Responsible Party Signature if different than Patient

EVERETT
3802 COLBY AVE., 3RD FLOOR
EVERETT, WA 98201
TEL 425.252.9333
FAX 425.303.8593

WWW.ALLSMILESDENTISTRY.NET

ALL SMILES
DENTISTRY

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 All Smiles Dentistry. 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 health care operations. The Statement of Privacy Practices also describes my rights and responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

All Smiles Dentistry 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 revision become's 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	□ **YES** □ **NO**
SPOUSE ONLY	□ **YES** □ **NO**
OTHER (PLEASE SPECIFY):	□ **YES** □ **NO**

_____ _____

Name of Patient or Personal Representative Date Signed

_____

Signature of Patient or Personal Representative

_____

Description of Personal Representative's Authority

OFFICE USE ONLY

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided Prior to Treatment? □ **YES** □ **NO**
Date Provided: _____
Reason for Denial:
□ **Needed more time to review statement of privacy practices.**
□ **Wanted to consult with another person, before signing.**
□ **Unable to sign.**
□ **Reason not given.**
□ **Other (Explain):** _____

EVERETT
3802 COLBY AVE., 3RD FLOOR
EVERETT, WA 98201
TEL 425.252.9333
FAX 425.303.8593
WWW.ALLSMILESDENTISTRY.NET

ALL SMILES
DENTISTRY

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 that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose 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 health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may given written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secured form unauthorized access and our employees are trained to make certain the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide out standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected form 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 Personal Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement as government 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 including voicemail/email 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 requestes 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.

Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

All Smiles Dentistry

EVERETT
3802 COLBY AVE., 3RD FLOOR
EVERETT, WA 98201
TEL 425.252.9333
FAX 425.303.8593

WWW.ALLSMILESDENTISTRY.NET