Patient Information and History (Confidential)

Patient Information (Please Fill Out Completely)

Name ____________________ SS# ____________________ Birthdate ____________________

Address ____________________ City ____________________ State __________ Zip ____________________

Home Phone ____________________ Cell Phone ____________________ Email ____________________

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married If Minor, Legal Guardian's Name ____________________

Patient's or Guardian's Employer ____________________ Work Phone ____________________

How did you hear about our office? ☐ Website ☐ Google Ad ☐ Facebook ☐ Yelp ☐ Insurance Provider

☐ Existing Patient ____________________ ☐ Other ____________________

Responsible Party (Please Fill Out Completely)

Name of Person Responsible for this Account ____________________ Relation to Patient ____________________

Address ____________________ Home Phone ____________________

Employer ____________________ Work Phone ____________________

Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information (Please Fill Out Completely)

Name of Subscriber ____________________ Relation to Patient ____________________

Birthdate ____________________ SS# ____________________ Date Employed ____________________

Employer ____________________ Work Phone ____________________

Dental Insurance Company ____________________ Group # ____________________ ID # ____________________

Address ____________________ City ____________________ State __________ Zip ____________________

Medical Insurance ____________________

Medical Plan ____________________ Medical ID# ____________________

Secondary Insurance Information (If Applicable)

Name of Subscriber ____________________ Relation to Patient ____________________

Birthdate ____________________ SS# ____________________ Date Employed ____________________

Employer ____________________ Work Phone ____________________

Insurance Company ____________________ Group # ____________________ ID # ____________________

Address ____________________ City ____________________ State __________ Zip ____________________

Release

- I authorize the Dental Health Providers at 425 Dental to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits.
- I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist.
- I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.
- I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental or medical care payor.
- I understand that I am financially responsible for payment in full of all accounts. Finance charges of 1% monthly will be applied to balances due over 90 days (per RCW 19.52)

Patient's or Responsible Party's Signature ____________________ Date ____________________

Dental/Medical History (Confidential - Page 1)

Dental History

Reason for Today's Visit ____________________ Date of Last Dental Visit ____________

Former Dentist ____________________ Date of Last Dental X-Rays ____________

Address ____________________

Check if you have had any of the following:

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection Between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Past Orthodontic Treatment
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Heat
- ☐ Sensitivity to Sweets
- ☐ Sensitivity When Biting
- ☐ Sores or Growths in Your Mouth

Are you apprehensive about dental treatment? ____________________

Are you dissatisfied with the appearance of your teeth? ____________________

Medical History

Physician's Name ____________ Physician Contact ____________ Date of last visit ________

Specialty Providers (e.g. Cardiologist) ____________________ Provider Contact ____________

Date of last visit ________

Have you ever taken any of the group of drugs collectively called "bisphosphonates" (examples of common bisphosonates include

Fosamax, Boniva, Actonel, etc.)? ☐ Yes ☐ No

Are you taking blood thinners? (Coumadin, Plavix, Aspirin, Vitamin E, Ginko biloba, Aggrenox, Pradaxa, Fish Oil, etc.)? ☐ Yes ☐ No

Do you currently or have you had mental health problems/anxiety/depression? ☐ Yes ☐ No

Have you had any serious illness or operation? ☐ Yes ☐ No If yes, please describe ____________________

Have you had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate date ____________________

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Have you been told by your medical provider that you need to take antibiotics before dental treatment? ☐ Yes ☐ No

Check if you have had any of the following:

- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Cough up Blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Sinus Trouble
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling Feet or Ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Veneral Disease

Please see reverse page.

Dental/Medical History (Confidential - Page 2)

Medications

List Medications you are currently taking and the correlating diagnosis:

____

____

____

____

Allergies

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Penicillin
- ☐ Sulfa
- ☐ Latex
- ☐ Other ____________

Sleep/Snore History

Question		
Do you snore or have you been told you snore?	☐ Yes	☐ No
Are you ever tired during the day?	☐ Yes	☐ No
Have you been told you quit breathing during sleep or awaken suddently in your sleep?	☐ Yes	☐ No
Do you ever wake up with headaches in the morning?	☐ Yes	☐ No
Have you been told to wear a CPAP device or do you wear a CPAP device?	☐ Yes	☐ No
Have you ever been asked to or have you taken a sleep study?	☐ Yes	☐ No
Do you take medication for high blood pressure?	☐ Yes	☐ No

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently, try to work out how they would have affected you. Please circle below.

	Chance of Dozing			
	Would Never	Slight Chance	Moderate Chance	High Chance
Sitting and reading	0	1	2	3
Watching TV	0	1	2	3
Sitting, inactive in a public place (e.g. a theater or meeting)	0	1	2	3
As a passenger in a car for an hour without a break	0	1	2	3
Laying down to rest in the afternoon when circumstances permit	0	1	2	3
Sitting and talking to someone	0	1	2	3
In a car, while stopped for a few minutes in traffic	0	1	2	3

Additional Information

Please indicate any additional areas you are interested in having the doctor discuss with you.

Orthodontics
- ☐ Invisalign
- ☐ Retainers

Cosmetic Dentistry
- ☐ Veneers
- ☐ Teeth Whitening

Botox
- ☐ Therapeutic (headaches, migraines, TMD)
- ☐ Cosmetic (wrinkles and fine lines)

Signature

The above information is accurate and complete to the best of my knowledge. I will not hold the Dental Health Providers at 425 Dental or their staff responsible for any errors or omissions that I may have made in completion of this form. I will inform the doctor if my health or medications change in any way.

Patient's or Responsible Party's Signature ______________________________ Date ____________

Office Policies & Notice of Privacy Practices

I authorize the release of my dental records to be sent out from the office of 425 Dental. I understand that there may be a duplication fee that is charged (in accordance with Section RCW 70.02, Medical Records).

Financial Policy

All patient portions will be due at the time of service. If you have insurance benefits, we will make a good faith estimate of your benefits and treatment costs with the information provided to us from your insurance company. As a courtesy, we will submit insurance claims on your behalf. If a claim is denied or payment is reduced for any reason by your insurance carrier, you will be responsible for the remaining balance on the account. Please keep in mind that your insurance coverage is a contract between the insurance company and your employer.

I acknowledge my responsibility for payment of the service received from 425 Dental in accordance with their regular fees and terms.

- I understand my responsibility is not modified by whether a third party (insurance) pays for: all, partial, or none of the charges.
- A finance charge of 1.0% per month may be accessed for any account which is not current or paid in full within 90 days from the date services were provided.

Assignment and Release

I authorize payment to be made directly to 425 Dental by my insurance company. Furthermore, I accept full financial responsibility for all services provided by 425 Dental, regardless of my dental insurance coverage. I authorize the release of any dental care information requested by my insurance company for the purpose of dental claim processing and/or payment.

Patient Name:____

Patient Signature:____

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