WASHINGTON DENTAL

PATIENT INFORMATION

Date_____ Nick Name_____

Patient _____
(First) (Middle) (Last)

Address _____
(Street) (Apt.) (City) (State) (Zip)

Sex: M / F Marital Status _____ Date of Birth _____

Home Phone Number _____ Work Phone Number _____ Cell # _____

Employer _____ Social Security # _____ TDL #_____

Spouse's Name _____ Date of birth _____

Employer _____ Work Number _____

Person Responsible for Paying This Account _____

Their Address (If different from above) _____
(Street) (Apt.) (City) (State) (Zip)

Their Home Phone Number _____

Whom should we thank for referring you to this office? _____

In Case of Emergency, who should we call? _____ Phone # _____

Name of nearest relative not living with you? _____ Phone # _____

Has any family member been seen in our office? Yes / No

Names _____

Dental Insurance? Yes / No Insurance Company_____ Phone #_____

Policy #_____Group #_____ Card Holder's Name_____

Social Security #_____ Date Of Birth_____

Employer_____Relationship To Patient_____

Deductible is to be paid **AT THE TIME OF SERVICE. As a courtesy to you we will file your Insurance for payment.** We will allow no more than *45* days from date of service for payment from your insurance company, at that time you will be expected to make payment in full or financial agreement must be in order.

Desired treatment _____

AUTHORIZATION TO PAY BENEFITS TO DENTIST: I hereby authorize payment directly to the Dentist or Dental Entity, if any, otherwise payable to me for his/her dental services as described,realizing I am responsible to pay non covered services.

_____
Signature

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Dentist to release any information acquired in the course of my dental treatment necessary to process insurance claims.

_____
Signature

OFFICE PAYMENT POLICY

PAYMENT IS EXPECTED WHEN SERVICES ARE RENDERED. **We accept cash, check, CareCredit, MasterCard & Visa.**

MEDICAL HISTORY

General health (please check) Excellent ____ Good ___ Fair ____ Poor ___

Name and Address of Physician _____

_____

Are you taking any medication now? Yes __ No ___ For what purpose? _____

Have you had any serious illness or accident in the last 5 years? Yes ___ No ___

Have you ever been treated for:

Heart Disease..... Yes ___ No ___
Abnormal blood pressure... Yes ___ No ___
Diabetes..... Yes ___ No ___
Hepatitis..... Yes ___ No ___
Rheumatic fever ..... Yes ___ No ___
Tuberculosis..... Yes ___ No ___
Sinus Trouble ..... Yes ___ No ___
Do you have a contagious disease ? .. Yes ___ No ___

Are you allergic to: Penicillin ___ Codeine ___ Local injected anesthetics___ Other medications _____

Do you smoke ? ..... Yes ___ No ___

(Women) Are you pregnant ? Yes ___ No ___ How many months ? _____

DENTAL HISTORY

Date of last dental visit? _____ Dentist's Name _____

Are you dissatisfied with the appearance of your teeth?.... Yes ____ No ___
Do you clench or grind your teeth? ..... Yes ____ No ___
Jaws click ? ..... Yes ____ No ___
Have you ever had pain in your jaw joint? ..... Yes ___ No ___
Do your gums bleed or have an unpleasant odor in your mouth?.... Yes ___ No ___
Have you had gum disease? ..... Yes ___ No ___
Is your mouth or teeth sensitive to Pressure? ..... Yes ___ No ___
Cold ? ..... Yes ___ No ___
Hot ? ..... Yes ___ No ___

Please add anything you feel is important for the doctor to know _____

_____

RIGHT TO PRIVACY–HIPPA

You have certain rights to privacy under the Health Insurance Portability and Accountability act of 1996 (HIPPA). By signing this you authorize for us to use and disclose your protected heath information to carry out:

-Treatment
-Obtaining payment from third party payers (e.g. your insurance company)
-The day to day healthcare operations of our practice.

You also have the right to review and secure a copy of the *Notice of Privacy Practices,* which contains a more complete description of the uses and disclosures of your protected heath information, and rights under HIPPA. We reserve the right to change the terms of this notice from time to time and you may contact us to obtain the most current copy of this notice. You have the right to request restrictions on how your protected health information is being used and disclosed to carry out treatment, payment, and heath care operations, but we are not required to agree to these requested restrictions. However if we do agree, we are then bound to comply with these restrictions.

You may revoke this this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected.

Date_____

Printed Name_____

Relationship to Patient_____

Signature _____