5th & Olive Dental

To assist us in serving you, please complete the following confidential form.
The information provided is important to your dental health.

Patient's name _____Birth Date _____ Email_____

Cell Phone _____Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Occupation _____

BILLING, INSURANCE INFORMATION: ❑ Not covered by dental insurance

Dental Insurance Co _____Group #_____ ID#_____

Your Social Security number: _____ Drivers License_____

Covered by spouse's insurance? ❑ yes ❑ no Spouse's Name_____

Spouse's dental insurance company _____ Group number _____ ID#_____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following

Y / N Cancer or tumor
Y / N Pace maker
Y / N Heart ailment or angina
Y / N Heart murmur, mitral valve prolapse, heart defect
Y / N Rheumatic fever or rheumatic heart disease
Y / N Artificial joint or valve
Y / N High or low blood pressure
Y / N Pacemaker
Y / N Tuberculosis or other lung problems
Y / N Kidney disease
Y / N Hepatitis or other liver disease
Y / N Alcoholism
Y / N Blood transfusion
Y / N Diabetes
Y / N Neurologic condition
Y / N Epilepsy, seizures, or fainting spells
Y / N Emotional condition
Y / N Arthritis
Y / N Herpes or cold sores
Y / N AIDS or HIV positive
Y / N Migraine headaches or frequent headaches
Y / N Anemia or blood disorders
Y / N Abnormal bleeding after extractions, surgery, or trauma
Y / N Hayfever or sinus trouble
Y / N Allergies or hives
Y / N Asthma

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Are you allergic to, or have you reacted adversely to any of the following?

Y / N Latex materials
Y / N Penicillin or other antibiotics
Y / N Local anesthetics ("Novocain")
Y / N Codeine or other narcotics
Y / N Sulfa drugs
Y / N Barbiturates, sedatives, or sleeping pills
Y / N Aspirin
Y / N Other:_____

Are you taking any of the following?

Y / N Aspirin
Y / N Anticoagulants (blood thinners)
Y / N Antibiotics or sulfa drugs
Y / N High blood pressure medicine
Y / N Antidepressants or tranquilizers
Y / N Insulin, Orinase, or other diabetes drug
Y / N Nitroglycerin
Y / N Cortisone or other steroids
Y / N Osteoporosis (bone density) medicine

List Medication

_____

_____

Women:

❑ Are you Pregnant? ❑ MIGHT BE PREGNANT

❑ Taking hormones or contraceptives

Dental History

Previous Dentist _____
Telephone

Date of last dental visit_____ Date of last dental x-rays _____

Are your teeth affecting your general health?	YES	NO	Have you experienced prolonged bleeding or slow		
Are you satisfied with your teeth and gums?	YES	NO	healing after a tooth extraction?	YES	NO
Do you have sore or sensitive teeth?	YES	NO	Have you had orthodontic treatment (braces)?	YES	NO
Have you ever been treated for periodontal disease?	YES	NO	Are you aware of grinding or clenching your teeth day or night?	YES	NO
Have you ever had serious complications with dental treatment?	YES	NO	Have you neglected regular dental visits in the past?	YES	NO
Do you want your teeth to be whiter?	YES	NO	Are you dissatisfied with the appearance of your teeth?	YES	NO

Patient Signature_____Date_____

5th & Olive Dental

Payment Policy:

Payment is due at time of service unless other arrangements have been made in advance. For your convenience we offer several payment options, including cash, checks and credit cards.

Dental Insurance:

Your Dental Insurance policy is a contract between you and your insurance company. It is your responsibility to know and understand your policy and dental coverage. We do accept most insurance benefits; however, we require your co-payment at the time of service.

Our fees are considered "usual and customary" for our area by Washington Dental Service and most other locally used insurance companies. Other dental insurances may have different standards for "usual and customary" fees, or they may pay on a defined benefits schedule. In some cases, reimbursement provided by the insurance carrier won't completely cover your costs. In these cases you are responsible to pay the difference.

Cancellation policy:

Our office requires a minimum of 24 hours notice if an appointment must be rescheduled or cancelled. Except in cases of emergency, failure to provide at least 24 hours notice before canceling an appointment will result in an assessment of a $75.00 fee to your account.

Saturday appointments

Our office requires a minimum of 48 hours notice if an appointment must be rescheduled or cancelled. Except in cases of emergency, failure to provide at least 48 hours notice before canceling an appointment will result in an assessment of a $150.00 fee to your account

I have read the above policies and understand my financial responsibilities as a patient.

*Patient Signature*_____*Date*_____

5th & Olive Dental

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 5th and Olive Dental. The Statement of Privacy Practices described 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 office health care options. The Statement of Privacy Practices also describes my right and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

5th and Olive Dental 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 revisions become 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 herby specifically authorize disclosures 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)		

If you were referred to our office by another patient, may we use your name In thanking them? Y N

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment and payment activities.

Authorization and Release

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payers and/or health practitioners. I consent to the use of my diagnostic models and dental records in consultation with other dentists for diagnostic and study purposes. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Name of Patient or Personal Representative Signature Date