PATIENT INFORMATION

Welcome to PUGET PARK 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 _____ Preferred name _____ Birth date_____

If minor, parents names _____ Home phone _____ Work phone _____

Mailing address _____ City _____State _____ Zip _____

Employer _____ Email _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you to our office? _____

BILLING, CREDIT, AND INSURANCE INFORMATION: ❑ **Not covered by dental insurance**

Your Social Security number: _____ Dental Insurance Co._____ Group number_____

Covered by spouse's insurance? ❑ yes ❑ no

Spouse's dental insurance company _____ Group number _____

Spouse's birthday _____ Social Security number _____

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following? (PLEASE CHECK ANY THAT APPLY)

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

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

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

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

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine
- ❑ Medications Currently Taking:

_____

_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Taking hormones or contraceptives

Name of your physician:_____

Do you have any disease, condition, or problem not listed above?_____

_____

Please add anything else you would like us to know about:_____

_____

Signature of patient (or parent) _____ Date _____

FINANCIAL POLICY

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options. Please select one.

- Cash, Check
- Visa, MasterCard, Discover, AMEX
- CareCredit (Financing)

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12%) per year will be charged on accounts 90 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

_____ _____

Signature of Patient/Guardian Date

CONSENT FOR TREATMENT

I consent to all procedures necessary for my dental diagnosis and care. These may include, but are not limited to; the use of x-rays, local anesthesia, medications and/or any other diagnostic/restorative procedures.

I, the undersigned patient, hereby authorize Puget Park Dental to perform the procedure(s) or course(s) of treatment.

I am aware of my right to waive treatment of any kind and I am aware of possible consequences of non-treatment.

I have disclosed my health history information, including allergies, reactions to medicine, diseases, and past procedures.

I authorize the undersigned provider and any other qualified assistants or medical professionals to perform the procedure(s) or treatment(s). I also give my consent for these individuals to administer any needed medicine and to perform any compulsory life-saving procedures.

I have read and understand the information contained within this form.

_____ _____

Signature of Patient/Guardian Date

APPOINTMENT GUIDELINES

Our office is designed to give each individual our personalized care, as a courtesy we do ask that if you need to change an appointment time that you give us 48 hours advanced notice so that we may give that time to someone else in need.

Any appointment that has not been given advanceNotice will be charged $50.00 per half hour as it is difficult to fill our schedule on a last minute basis.

Please understand that this is necessary for us to do as we schedule on a patient to doctor basis, we do not "doubleBook" so that we may give you the best care possible.

I have read and understand the information contained within this form.

_____ _____

Signature of Patient/Guardian Date

ACKNOWLEDGEMENT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Puget Park Dental. 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 office health care operations. The Statement of Privacy Practices also describes my rights 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.
Puget Park 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 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 Signature of Patient or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

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): _____