New Patient Information

Date: ______________________

Name (first,middle init.,last)____

Address:__________________________________ City:___________________State:______ Zip:__________

Date of Birth:________________ SSN:#__________________________ Sex:_________

Marital Status_________________ Employer: ____

Dental Insurance:__________________________________ Group #_________ID#_____________________

IF Spouse or another person is Primary on Insurance - Subscriber's Name: ___________________________

Subscriber's Employer:____

Subscriber's SSN#: ___________________________ Subscriber's Date of Birth: _______________________

Phone Numbers/Email

Home: (______) _________________ Cell: (_______)_________________ Work: (_____)________________

Email Address: ____

In Case of Emergency, Contact:

Name:____ Relationship:_____________________

Phone Number: (____) _________________ Cell: (____) ____

Dental History

Reason for today's visit?____

Date of last dental visit: _____________________ What was done:_________________________________

Previous Dentist Name:_________________________ Location:__________________________________

How often do you: Have Examinations: __________________ Brush: __________ Floss:___________

Indicate if you have had or are presently having any of the following:

Sensitivity to Hot or Cold _______
Sensitivity to Sweets _______
Biting or Chewing Pain _______
Mouth Odors/Halitosis _______
Cold Sores/Oral Lesions _______
Bleeding/Swollen Gums _______
Family History of Gum Disease _______

Loose teeth/Change in Bite _______
Food collection between teeth _______
Periodontal treatment/surgery _______
Clenching or grinding of teeth _______
Bite lips or cheek regularly _______
Clicking or popping of jaw _______

Difficulty opening/closing mouth _______
Head, Neck or Shoulder Aches _______
Have tired jaws, especially in a.m. _______
Orthodontic treatment _______
Oral Surgery _______
serious injury to mouth/head _______
If so, please describe:____

Are you satisfied with the appearance of your teeth? Y__ N__
Do you feel nervous about having a dental visit? Y__ N__

If So, What is your biggest concern:_______________________________

Is there anything else about having dental treatment that you would like for us to know?

____

Patient Signature: ____ Date: ____________________

Patient Health History

____
Patient Name

Have you been under the care of a doctor and/or been hospitalized during the past 2 to 5 years? If YES, please describe: ____

Physician's Name, Address and phone: ____

Indicate which of the following you have HAD, or have AT PRESENT:

Heart (surgery, disease, Attack)	_____	Ulcers /Gastric Reflux	_____	Hepatitis	_____
Chest Pain/Angina	_____	Diabetes Type I or II	_____	STD	_____
Congenital Heart Disease	_____	Thyroid Problems	_____	AIDS/HIV	_____
Heart Murmur/or defects	_____	Glaucoma	_____	Cold Sores	_____
High or Low Blood Pressure	_____	Contact Lenses	_____	Blood Transfusions	_____
Artificial/Damaged Heart Valve	_____	Emphysema	_____	Hemophilia	_____
Heart Pacemaker	_____	Tuberculosis	_____	Sickle Cell	_____
Stroke	_____	Chronic Cough	_____	Bruise Easily	_____
Rheumatic Fever	_____	Asthma	_____	Liver Disease	_____
Arthritis/Rheumatism	_____	Hay Fever, Sinus Trouble	_____	Neurological	_____
Cortisone Medication	_____	Migraines	_____	Yellow Jaundice	_____
Swollen ankles	_____	Cancer	_____	Disorders	_____
Diet (Special /Restricted)	_____	Tumors	_____	Epilepsy/Seizures	_____
Artificial Joints (hips, knees, etc.)	_____	Sleep Disorders	_____	Fainting/Dizzy	
Kidney Trouble	_____	Allergies/Hives	_____	Spells	_____
Frequent Urination	_____	Latex Sensitivity	_____	Psychiatric Care	_____

Women:
(Are you now pregnant? Yes____ No ____ Nursing? Yes_____ No ____ Chance that you are pregnant? Y____ N_____)

Do you use drugs, tobacco products or any other substance? If yes, please list and describe frequency of use:____

Medications

Has a physician or previous dentist recommended that you take antibiotics prior to dental treatment?
Yes____________ No _______________

List any medications you are currently taking and the correlating diagnosis for their use: (If you have a list prepared already, please provide a copy for your chart)

____
____

Allergies/Reactions/Intolerance (Circle any that you cannot take)

Amoxicillin	Aspirin	Morphine	Cephalosporin	Erythromycin	Ciprofloxacin
Clindamycin	Penicillin	Augmentin	Codeine	Sulfa	Vicodin

Other:____

Patient Signature: ____ Date: ____________________

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Jacob Boyack or Dr. Richard Ruder, dental assistants and hygienists to perform the following treatment: Dental X-rays ____ Oral Evaluation ____ Prophy Cleaning (regular cleaning) _____

Print Patient Name: ____

Patient Signature: ____ Date: ____________________

(Legal Guardian if under 18 yrs)____

X_____ I fully disclosed all health problems, including but not limited to heart conditions, high or low blood pressure, diabetes, need for antibiotic prior to dental treatment (due to prosthetic valves, joints or heart conditions), medications taken/prescribed, bleeding problems and allergies.

Patient Policies

Please review, initial where indicated and sign at the bottom of page. *Thank you.*

Advanta Dental provides general dentistry services. It is our policy that payment is due at the time of service, unless signed specific payment arrangements have been agreed upon. X______ (Initial)

We accept **MasterCard**, **Discover, Visa, American Express, Cash**, **Care Credit** and **Personal Checks**. (In the event of a returned check from your bank, a $40 NSF fee will be assessed. X _____ (Initial)

Please present your Dental Insurance Card to our front desk personnel if you have dental insurance. As a courtesy, we will submit claims to your insurance company. We will provide you with an ESTIMATE for treatment to be rendered at each appointment. Any unpaid balance once benefits have been applied will be the responsibility of the patient. X ______ (Initial)

Broken Appointments: When appointments are made time is reserved exclusively for you and is customized according to the work that will be done for you that day. If you need to reschedule your appointment, we require 48 hours notice. Failure to keep a confirmed appointment may result in a broken appointment fee of $75. X _______ (Initial)

Complete this section <u>ONLY IF</u> you are interested in the Care Credit Payment Option:

Care Credit, 12 months, 0% interest

Name____ **Date of Birth**________________

Social Security #________________________________ **Home Phone**________________________________

Cell Phone_______________________ **Address**____

Do you OWN____ RENT_____ *Approximate* annual household income: $___________________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Advanta Dental
321 N. Sequim Ave, Suite D
Sequim Wa 98382

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain Payment from third-party payers for my health care services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the notice.

I further understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my restrictions, but if you do agree, then you are bound to abide by such restrictions.

____ ______________________________
Patient Name Date

__________________________________ _____________________________________
Signature Parent or Guardian if patient is under 18

Dependent family members also covered by this acknowledgement: ______________________

Please select or otherwise indicate to whom we may disclose your dental health information:

Any member of my immediate family ----------------------------- Yes____ No ____

Spouse Only-- Yes____ No ____

Other, please specify: ____

____

For Office Use Only:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy due to the following reason: ____
____