Aesthetic & Family Dentistry
OF WASHINGTON

PATIENT INFORMATION FORM

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Today's Date:_____

Personal History:

Name: Mr./Mrs./Ms./Dr._____
Last First MI

I prefer to be called:_____ Δ Male Δ Female

Birthdate:____/____/____ **Age:**_____ **SS#:**_____

Home Address: _____
Street Address Apt/Condo #

_____
City State Zip Code

⌋ Single ⌋ Married ⌋ Divorced ⌋ Widowed ⌋ Separated

Home #: (____)_____ Pager/Cell #: (_____)_____

Work #: (_____)_____ Ext.: _____

Email Address:_____

Employer: _____

Employer's Address: _____

How long there?_____ Occupation: _____

When & where are the best times to reach you: _____

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____
(Please Circle)

Last Visit Date: _____

Person Responsible for Account: _____

Contact Telephone: _____

Billing Address: _____

_____

Relation:_____

SS#: _____

Employer: _____

Spousal Information

His/Her Name:_____

Employer:_____

Work #: ( )_____Ext.: ____

SS #: _____

Birthdate / /____

Dental Information

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____)_____
Group # (Plane, Local or Policy #): _____
Insured's Name: _____
Relation:_____
Insured's Birthdate:____/____/____
Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Co. Phone #: (____)_____
Group # (Plane, Local or Policy #): _____
Insured's Name: _____
Relation:_____
Insured's Birthdate:____/____/____
Insured's ID #: _____
Insured's Employer: _____
Employer's Address: _____

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Emergency Contact

His/Her Name:_____Relation: _____

Work #: (_____)_____ Home #: (_____)_____

Medical History

Have you ever had any of the following diseases or medical problems? (Please circle option that applies)

Y N Anemia / Radiation Treatment
Y N Artificial Bones / Joints / Valves
Y N Arthritis
Y N Asthma
Y N Blood Transfusion
Y N Cancer / Chemotherapy
Y N Congenital Heart Defect
Y N Diabetes
Y N Difficulty Breathing
Y N Drug/Alcohol Abuse
Y N Emphysema / Glaucoma
Y N Epilepsy/Seizures / Fainting Spells
Y N Fever Blisters / Herpes
Y N Heart Attack / Stroke
Y N Heart Murmur
Y N Heart Surgery / Pacemaker
Y N Hemophilia / Abnormal Bleeding
Y N Hepatitis
Y N High / Low Blood Pressure
Y N HIV+ / AIDS
Y N Hospitalized for Any Reason
Y N Kidney Problems
Y N Mitral Valve Prolapse
Y N Osteoporosis (or currently taking medication for such)
Y N Psychiatric Problems
Y N Rheumatic / Scarlet Fever
Y N Sever / Frequent Headaches
Y N Shingles
Y N Sickle Cell Disease / Traits
Y N Sinus Problems
Y N Tuberculosis (TB)
Y N Ulcers / Colitis
Y N Venereal Disease

Current Medical Physician:_____ **Wk #:**_____

Please list any serious medical condition(s) that you have ever had:

_____
_____

Are you currently taking any prescription medications:_____

Are you allergic to any of the following?

Y N Aspirin Y N Erythromycin Y N Penicillin Y N Codeine Y N Jewelry / Metals
Y N Tetracycline Y N Dental Anesthetics Y N Latex Y N Other

Please list any other drugs / materials that you are allergic to:_____

Dental History

Why have you come to the dentist today?

_____
_____

⌋ Yes Δ No Do you require antibiotics before dental treatment?
⌋ Yes Δ No Are you currently in pain?
⌋ Yes Δ No Have you ever had a serious / difficult problem associated with any previous dental work?
⌋ Yes Δ No Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ/TMD)?
Your current dental health is: Δ Good Δ Fair Δ Poor
⌋ Yes Δ No Do you like your Smile?
⌋ Yes Δ No Do your gums ever bleed?
⌋ Yes Δ No Have you ever had periodontal disease?
How many times a week do you floss?_____a day do you brush? _____
Type of bristles? Δ Hard Δ Medium Δ Soft

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent. Patient is requested to provide a minimum of 24-hours notice for the cancellation of an appointment, otherwise the patient will be charged for the appointment.

_____ _____
Signature Date

Office Use Only

I verbally reviewed the medical / dental information above with the patient named herein. Initials:_____Date:_____

Doctor's Comments:_____
Medical History Update:
1. Date:_____Comments:_____Signature:_____
2. Date:_____Comments:_____Signature:_____

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Patient Consent Form

The Department of Health and Human Services has established the "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain the patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our patient, we would like you to know that we respect the privacy of your personal dental records and will do all that we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment, or health care operations, in order to provide health care that is in your best interest.

We also would like you to know that we support your full access to your personal dental records. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse disclosure of your Personal Health Information (PHI). If you choose to give consent to this document at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken, which relied on this or previously signed consent.

If you have objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____Signature:_____Date:_____

Compliance Assurance Notification for Our Patients

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients aggravation, inconvenience, and money. We would like you to know that all of our employees, managers, and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate use of PHI in accordance with the government rules, laws, and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued patients.

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Insurance Inquiries Form

Dear Patient,

The employees of Aesthetic and Family Dentistry will gladly provide assistance to all patients who may have inquiries about their dental insurance benefits, estimate of a proposed treatment plan, pending claims, eligibility for dental insurance coverage, and other insurance/billing questions. However, it is the patient's responsibility to be familiar with their own dental insurance plan.

Patients may obtain all of the necessary information by calling the toll free phone number located on their insurance card. However, if the patient wishes for our office to contact their insurance provider on the patient's behalf regarding eligibility and benefits, claims, available coverage, estimate of cost for a proposed treatment plan, or any other inquiry, they are strongly advised to schedule a complimentary and private consultation with our insurance and treatment coordinator. All insurance and financial concerns should be addressed and resolved before the scheduled treatment appointment with the doctor. We do the aforementioned services as a courtesy to our patients, as we are not obligated to provide assistance with the patients' insurance. We are not affiliated in any way with any medical or dental insurance plans, or flexible spending accounts.

We recommend this complimentary service to our patients in order to eliminate any potential issues and concerns that may arise.

Your insurance company will be billed for applicable charges after today's service. Should there be any remaining balance after your insurance is charged, you will be responsible for paying these remaining charges. You may also be liable for any agency fees associated with collecting the balance of any remaining charges left due and unpaid after a 90-day period. By signing this form, you agree to this.

Please print and sign your name below in acknowledgement of having read and understood this form. Thank you for being one of our highly valued patients.

Signature:_____ Date: _____

Printed name: _____

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Broken Appointment/Cancellation Policy

Welcome to Aesthetic and Family Dentistry! We are glad that you have made an appointment with us for your oral health care. Regular dental visits are vital in keeping your teeth and gums healthy.

It is important that you keep your appointment with us! Valuable time has been reserved for your care, and a missed appointment results in lost time that could have been used by another patient waiting to receive treatment.

We require 48-hour advanced notice when cancelling an appointment that has been reserved for you. This is subject to a broken appointment fee of $75 for each hour for which your appointment was scheduled.

Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for several appointments may result in dismissal from this practice.

I have read the above policy, and agree to abide by it.

_____ _____

Signature of Client (or Parent/Guardian) Date

_____

Printed Name

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Oral Cancer Screening Form

Our practice continually looks for medical advances to ensure that we are providing the highest level of oral health care to our patients. We are concerned about oral cancer and look for it in every patient.

One American dies every hour from oral cancer. Late detection of oral cancer is the primary cause that both the incidence and mortality rates of oral cancer continue to increase. As with most cancers, age is the primary risk factor for oral cancer. **Tobacco and alcohol use are other major predisposing risk factors, but more than 25% of oral cancer victims have no such lifestyle risk factors.** Oral cancer risk by patient profile is as follows:

Increased risk:	Patients ages 18-39
High risk:	Patients age 40 and older; tobacco (within 10 years) users of any age
Highest risk:	Patients age 40 and older with lifestyle risk factors (tobacco and/or alcohol use; previous history of oral cancer)

We have recently incorporated ViziLite Plus into our oral screening standard of care. We find that using ViziLite Plus along with a standard oral cancer examination improves the ability to identify suspicious areas at their earliest stages. ViziLite Plus is similar to proven early detection procedures for other cancers, such as mammography, Pap Smear, and PSA. ViziLite Plus is a simple and painless examination that gives the best chance of finding any oral abnormalities at their earliest stages. Early detection of pre-cancerous tissue can minimize or eliminate the potentially disfiguring effects of oral cancer and possibly save your life. The ViziLite Plus exam will be offered to you annually.

This enhanced examination is recognized by the American Dental Association code revision committee as CDT-5 procedure code D0431; however, this exam may not be covered by your insurance. The fee for this enhanced examination is **$65.00**. Please print and sign your name below under **Yes** or **No**, according to your choice regarding the ViziLite Plus examination.

Yes, I authorize the clinician to perform the ViziLite Plus exam along with the standard oral cancer exam. I accept the financial responsibility for this enhanced examination.

Print Name:_____

Signature:_____ Date:_____

No, I would prefer not to have the ViziLite Plus exam at this time.

Print Name:_____

Signature:_____ Date:_____

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