Dental Designs Of Washington
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Dental Designs
of Washington

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ☐Male ☐Female Family Status: ☐Married ☐Single ☐Child ☐Other

Birth Date: _____ (00/00/0000) **SS#:** _____ (000/00/0000) **Prev. Visit:** _____ (00/00)

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Employer and Occupation: _____

In an emergency who should be notified? Please enter Name and Phone number below:

_____

Whom may we thank for referring you to our practice?

_____

Responsible Party Information:
Please enter information for the person financially responsible for the account

☐ **If the Patient is the responsible party, please check here, skip this section and continue to the next section.**

The following Is for: ☐ the patient's spouse ☐ the person responsible for payment ☐ both ☐ neither-not applicable

Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) **Gender:** ☐ Male ☐ Female **Family Status:** ☐ Married ☐ Single ☐ Child ☐ Other

Birth Date: _____ (00/00/0000) **SS#:** _____ (000/00/0000) **Prev. Visit:** _____ (00/00)

Email Address: _____ **Best time to call:** _____

Phone: _____ (Home) _____ (Mobile) _____ (Work)

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Dental Insurance Information

Primary Dental Insurance:

Name of Insured : _____ (Last) _____ (First) _____ (MI)

lnsured's Birth Date: _____ (00/00/0000) **ID#** _____ **Group#** _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

lnsured's Employer Name: _____

Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Patient's relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____ (Zip Code)

Insurance Company Phone Number: _____

Insurance Authorization:

☐ ***By checking this box,***

I authorize my Insurance company to pay the dentist all Insurance benefits rendered
I authorize the use of this electronic signature on all Insurance submissions.
I authorize the dentist to release all Information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by Insurance.

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(If you have Secondary Dental Insurance,
please present your insurance card to the front desk at the time of your appointment)

Dental History Information

What is the reason for your visit today? _____

_____

How would you rate the condition of your mouth?
☐ Excellent ☐ Good ☐ Fair ☐ Poor

How would you rate your pain level today if any?
Not at all* 0 1 2 3 4 5 6 7 8 9 10 *Painful

Previous Dentist Name and Phone Number: _____

_____

Date of most recent dental exam and dental X•rays: _____

I routinely see my dentist every:
☐ 3 months ☐ 4months ☐ 6 months ☐ 12months ☐ Not routinely

Check all that apply:

- ☐ Had complications from past dental treatment
- ☐ Had any reactions to local anesthetic
- ☐ Have dry mouth
- ☐ Food gets trapped between any teeth
- ☐ Have popping and/or clicking of your jaw joint
- ☐ Clench or grind your teeth
- ☐ Gums bleed when brushing or flossing
- ☐ Have or had gum recession
- ☐ Have or had a burning sensation in your mouth
- ☐ Would like to change the appearance of my smile
- ☐ Had trouble getting numb
- ☐ Had or have braces (orthodontic treatment)
- ☐ Teeth are sensitive to hot, cold, biting or sweets
- ☐ Have whitened or bleached your teeth
- ☐ Have difficulty chewing
- ☐ Wear or have worn a bite appliance
- ☐ Have been treated for gum disease
- ☐ Had an unpleasant taste or odor in your mouth
- ☐ Snore or wake up frequently during the night

If any of the checked boxes need further explanation, please describe:

_____

_____

_____

_____

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time services are performed unless other arrangements are made.

**** All treatment plans prices are estimates, not guarantees.****
****Please contact your insurance provider with any questions about exact fees****

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Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1.5% per month {18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.
In consideration for the professional services rendered to me by this practice, l agree to pay the charges for the services at the time of treatment, or within five (5)days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me. in writing, with!□ the time payment is due. 1 further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or cond1t1on and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

☐ **I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.**
*** By checking this box, I understand the above Information and agree with Its contents, and this will serve as my electronic signature**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized. or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so. may not be subject to federal or state law protecting its confidentiality.

I authorize this office to disclose or discuss my personal and/or dental Information with the following person(s).

_____

(Please enter name and relationship to patient.)

☐ *** By checking this box, I understand the above Information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form**

Consent for Internet Communications

I grant my permission to the dental practice to upload and store confidential patient information (including account information. appointment information and clinical information) to the secured web site for the dental practice. I understand that, for security purposes, the site requires a user ID and password for access and use. ! also understand the dental practice and I are responsible for maintaining the strict confidentiality of any ID and password assigned to me; and that the dental practice is not liable for any charges, damages, or losses that may be incurred or suffered as a result of my failure to maintain confidentiality. I understand the dental practice is not liable for any harm related to the theft of my ID and password, my disclosure of my ID and password, or my authorization to allow another person or entity to access and use the dental practice web site with my ID and password. I also agree to immediately notify the dental practice of any unauthorized use of my ID or of any other need to deactivate my ID due to security concerns.

I also understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure. maintenance. and storage of my information. and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I agree that the dental practice has the right to monitor, retrieve, store, upload and use my information in connection with the operation of such services, and is acting on my behalf in uploading my patient information. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information that is uploaded to the web site on my behalf. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PA TI ENT INFORMATION OR OTHER INFORMATION TRANSMITTED, MONITORED, STORED, UPLOADED OR RECEIVED USING THE SITE OR THE SERVICES.

☐ *** I have read the Information above regarding the secured uploading of patient Information to the web site for the dental practice, and grant the dental practice permission to securely upload my patient Information to the web site. This will serve as my electronic signature.**

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 24 hours working day in advance.

Our doctors & hygienists want to be available for your needs and the needs of all our patients. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no show appointments.

Patient who do not notify the office within a 24-hour working day will be subject to a cancellation fee of$ 50.00
Patients who do not show for a scheduled appointment will be subject to a no show fee of$ 75.00

Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients.

☐ ***By checking this box, I understand the above Information and agree with Its contents, and this will serve as my electronic signature or the for Cancellation Policy.**

Name of person completing this form: _____

Relationship to patient: _____

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Response Date: _____