PATIENT INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: ______________________ Date of birth: ____________ Sex: ________ Age: ______

Home address: ______________________ City: ____________ State: ______ Zip: ____________

Billing address (if different): ______________________ City: ____________ State: ______ Zip: ____________

Home phone: ____________ Cell: __________ E-mail: ______________________

SS #: ______________________ Employer/Occupation: ______________________ Bus. Phone: ______________

Spouse's name & phone #: ______________________ Emergency phone # (other than spouse): ______________

Primary dental insurance: ______________________ Group #: ______________________

Secondary dental insurance: ______________________ Group #: ______________________

Subscriber's name: ______________________ Date of birth: ____________ SS #: ______________

Name of your medical doctor: ______________________ Date of last visit to medical doctor: ______________

Name of previous dentist: ______________________ Date of last visit to dentist: ______________

Referred to us by: ______________________ ______________________

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? ______________		
How often do you floss? ______________		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems ______	☐	☐
Chest pain ______	☐	☐
Shortness of breath ______	☐	☐
Blood pressure problem ______	☐	☐
Heart murmur ______	☐	☐
Heart valve problem ______	☐	☐
Taking heart medication ______	☐	☐
Rheumatic fever ______	☐	☐
Pacemaker ______	☐	☐
Artificial heart valve ______	☐	☐
Blood Problems ______	☐	☐
Easy bruising ______	☐	☐
Frequent nosebleeds ______	☐	☐
Abnormal bleeding ______	☐	☐
Blood disease (anemia) ______	☐	☐
Ever require a blood transfusion? ______	☐	☐
Allergy Problems ______	☐	☐
Hay fever ______	☐	☐
Sinus problems ______	☐	☐
Skin rashes ______	☐	☐
Taking allergy medication ______	☐	☐
Asthma ______	☐	☐
Intestinal Problems ______	☐	☐
Ulcers ______	☐	☐
Weight gain or loss ______	☐	☐
Special diet ______	☐	☐
Constipation/Diarrhea ______	☐	☐
Kidney or bladder problems ______	☐	☐
Bone or Joint Problems ______	☐	☐
Arthritis ______	☐	☐
Back or neck pain ______	☐	☐
Joint replacement ______ (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy ______	☐	☐
Stroke(s) ______	☐	☐
Frequent or severe headaches ______	☐	☐
Thyroid problems ______	☐	☐
Persistent cough or swollen glands ______	☐	☐
Premedications required by physician ______	☐	☐
Cancer/Tumor ______	☐	☐

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

	Yes	No
Local anesthetics (“Novocaine”)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other ______		

Notes: ______

______

______ Date: ______

	Yes	No
Diabetes ______	☐	☐
Urinate more than 6 times a day ______	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes ______	☐	☐
Tuberculosis or other respiratory disease ______	☐	☐
Do you drink alcohol? ______ If so, how much? ______	☐	☐
Do you smoke? ______ If so, how much? ______	☐	☐
Hepatitis, jaundice, or liver trouble ______	☐	☐
Herpes or other STD ______	☐	☐
HIV-positive/AIDS ______	☐	☐
Glaucoma ______	☐	☐
Do you wear contact lenses? ______	☐	☐
History of head injury? ______	☐	☐
Epilepsy or other neurological disease? ______	☐	☐
History of alcohol or drug abuse? ______	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: ______

Medications & suppliments

______

______

______

______

______

______

______

Women	**Yes**	**No**
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant? **If so, expected delivery date:** ______	☐	☐
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? ______		

Notes: ______

______

Patient/Parent Signature: ______

Dentist Initial: ______

Quality Family Dentistry

Aaron Marks, DMD
14818 179th Ave SE Monroe WA 98272
360-805-8585

Financial Policy

We appreciate that you have many choices in your dental care and we value you. To provide each of our patients with the best dental care this is the policy we have established.

Payment is required at time of service

Ways to settle your financial obligation:

1. Insurance:
    a. We bill your insurance as a courtesy to you. We do our very best to give an accurate ESTIMATE, however it is between you and your insurance what they will pay.
2. Cash
3. Credit Card
4. Check
    a. If the check is returned there will be a $30 fee placed on your account and no treatment will be rendered until you settle your account.
    b. Once you settle your account we will only accept full payment at time of setting your appointment with either cash or credit card. We will not accept checks from you anymore.
5. Care Credit
    a. This is a third party credit agency that you can apply for and use for medical expenses.
    b. There will be a credit check completed to check eligibility.

I, ________________________________ agree to the above terms and will settle my accounts as treatment is rendered. I understand that no treatment will be rendered without payment. I understand that this dental office is not set up to offer loans and/or credit.

____ __________________________
Signature Date

We look forward to a long and lasting relationship with you!
Thank you for your trust, we will work our very hardest to keep it!

<u>MISSED APPOINTMENT POLICY</u>
<u>48 Hours</u>

We want to thank you for choosing us as your health care provider. In order to give you and all our patients, the best possible care, we request that you review our policy regarding missed appointments.

A missed appointment is when you fail to show up for an allotted appointment time, without a phone call or cancellation notice of at least **48**-hours. Please remember that we have reserved appointment times especially for you. Therefore, we request at least a **48** hour notice in order to reschedule your appointment. This will enable us to offer your cancelled time to other patients.

If you are unable to keep your scheduled appointment time, please call our office at least **48**-hours in advance in order to avoid a missed appointment fee. This charge is not covered by insurance. Your phone call is critical in helping us provide continuous care to all of our valued patients. If you fail to give us notice of your missed appointment, you will be charged a $55 per hour (of your scheduled appointment) missed appointment fee

I have read and understand the policy stated above:

Printed Name: ____

Signature: __________________________________ Date: __________

Your Dental Goals

What is your #1 concern about your teeth? ______________________________

What is your #2 concern? ______________________________

Circle how anxious you are about coming to the dental office:

(None) 1 2 3 4 5 6 7 8 9 10 (Severly)

Besides getting numb, is being sedated something that you want? Yes No

What is your biggest fear of being here? ______________________________

Do you have a history of bad experiences in other dental offices? Yes No

If yes, please describe in short ______________________________

Do you have a history of facial/dental trauma/injury? Yes No

If yes, please describe in short ______________________________

Anything else you wish for me to know?

____

____

____

Medical Information Release Form (HIPAA Release Form)

Patient Name: ____ Date of Birth: ____/____/__________

Release Information

[ ] I authorize the release of information including the diagnosis, records, examination rendered to me and claims information. This information may be released to:

[ ] Spouse ____

[ ] Child(ren) ____

[ ] Other ____

[ ] Information is not to be released to anyone

This Release of Information will remain in effect until terminated by the patient in writing.

Messages

Please call: [ ] my home [ ] my work [ ] my cell phone

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] other instructions: ____

The best time to reach me is : ____

Signed: ____ Date: ___/___/_____

Witness: ____ Date: ___/___/_____

Quality Family Dentistry www.marksdmd.com

Patient Acknowledgment of Receipt of Notice of Privacy Practices

Please Print

I, ______________________________, hereby acknowledge that I have reviewed and received a copy of this office's *Notice of Privacy Practices* explaining:

- How this office will use and disclose my protected health information.
- My privacy rights with regard to my protected health information.
- This office's obligations concerning the use and disclosure of my protected health information.

I understand that the *Notice of Privacy Practices* may be revised from time to time and that I am entitled to receive a copy of any revised *Notice of Privacy Practices* upon request.

I also understand that if I have any questions or complaints, I may contact:

Aaron Marks DMD PLLC: Quality Family Dentistry

14818 179th Ave SE Monroe WA. 98272

____

You may also contact the Secretary of the U.S. Department of Health and Human Services with any concerns regarding our privacy and security policies and procedures. Please contact our office for information on how to contact the U.S. Department of Health and Human Services.

Patient or Personal Representative

Signature: ______________________________ Date: ___/___/___

Name: ______________________________
Please Print

Relationship to Patient: ______________________________

For Office Use Only

We made a good-faith effort to obtain an acknowledgment of ______________________________'s receipt of our Notice of Privacy Practices. In spite of these efforts, our office has been unable to obtain a signed acknowledgment of receipt for the following reasons (check all that apply):

☐ Patient refused to sign (date of refusal) ___/___/___.

☐ Communications barriers prohibited obtaining an acknowledgment.

☐ An emergency situation prevented us from obtaining an acknowledgment.

☐ Other ______________________________

Attempt was made by: ______________________________ Date: ___/___/___

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ATTORNEY APPROVED