**PATIENT INFORMATION** Date:_____

Last Name, First Name,M.I._____

Preferred Name _____ M__F__ Date of Birth_____

Address_____City_____State___Zip_____

SSN_____ /Insurance ID#_____ Minor__Single__ Married__

Driver's License#_____ _____ Widowed__Divorced__

If Student, Name of School_____Full Time__Part Time__

Home Phone_____Work Phone_____Cell Phone_____

Do you prefer to receive calls Home__Work__Cell__? E-Mail address_____

Employer _____Occupation_____

Employer address_____Phone#_____

Insurance Company _____Phone#_____

In case of an emergency, whom should we contact?_____Phone#_____

Whom may we thank for referring you?_____

**SPOUSE / PARENT INFORMATION**

Last Name, First Name, M.I._____

Date of Birth_____SSN_____InsuranceID#_____

Spouse Employer_____Occupation_____

Employer address_____Phone#_____

Insurance Company _____Phone#_____

The Mill Creek Dentist
16306 Bothell-Everett Hwy, Suite B
Mill Creek, WA 98012
(425) 745-4661

# HEALTH INFORMATION

| | Yes | No |
|---|---|---|
| Has there been any change in your general health within the past year? | ☐ | ☐ |

If yes please describe: _____

| | | |
|---|---|---|
| Are you currently under the care of a physician? | ☐ | ☐ |

If yes, please explain: _____

| | | |
|---|---|---|
| Have you had any serious illnesses, surgeries, or hospitalizations? | ☐ | ☐ |

If yes, please explain: _____

Do you have or have you had any of the following: (Please circle all that apply)

Rheumatic fever Congenital heart disease Cardiovascular disease Artificial or replacement heart valves

Pacemaker Sinus problems Asthma or hay fever Hives or skin rash Fainting spells Seizures

Heart trouble Heart attack Heart murmur Arteriosclerosis High or low blood pressure Stroke

Hepatitis Jaundice Liver disease Diabetes Cancer/Tumor Arthritis Rheumatism Artificial joints

Digestive problems Stomach disorders Kidney trouble AIDS HIV STD Herpes TB

Bleeding problems Epilepsy Bruise easily Anemia Radiation, chemotherapy or other cancer treatment

Glaucoma Alcoholism Substance abuse Blood transfusion Persistent cough or cough up blood

If you circled any of the above, please explain: _____

_____

Please list any allergies (including medications, latex, or metals) that you have: _____

_____

Please list any medications (including vitamins and herbs) you are taking: _____

_____

Do you drink alcohol or use tobacco products? If so, how much? _____

Do you have any disease, condition or health problem not listed above. If so, please explain below:

_____

Name and telephone # of your medical doctor: _____

What is the approximate date of your last visit to a medical doctor: _____

WOMEN:

Are you pregnant or nursing? _____ Taking birth control ___ or hormone replacement therapy? _____

# DENTAL INFORMATION

What is the purpose of this appointment? _____

Do you have dental pain at this time? Severe ☐ Moderate ☐ Slight ☐ None ☐

Date of last dental visit: _____ Last dental cleaning: _____

Does dental treatment make you anxious? Extremely ☐ Moderately ☐ Slightly ☐ No ☐

Do you have or have you had any of the following: Please circle all that apply:

Bleeding, sore gums Unpleasant taste, bad breath Loose teeth Burning tongue, lips Swollen gums

Frequent blisters on lips or mouth Swelling or lumps in mouth Difficulty opening or closing jaw

Orthodontic treatment Clicking, popping jaw Clenching or grinding Food impaction TMJ

Tired jaws Dry mouth Uncomfortable bite Floss catches Change in bite

Sensitive to: Hot Cold Sweets Biting Chewing

If you circled any of the above please explain: _____

_____

Are you satisfied with the appearance of your teeth? Yes ☐ No ☐

If not, what is it you would like to change? _____

Name of previous dentist: _____ May we contact that office for records? Yes ☐ No ☐

What, if any, premedications have been recommended for you to take prior to dental appointments? _____

_____

Have you had difficulty or problems with past dental treatment experiences. If so, please explain.

_____

_____

HIPAA
ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I,(your name) _____, have received a copy of this office's notice of privacy practices.

_____
Please Print Name

_____
Signature Date

_____

## APPOINTMENT POLICY

It is important to understand that when you make an appointment you have hired one doctor or hygienist, a receptionist and a dental assistant. When a patient misses an appointment, they often think "it's okay" because the doctor has other patients he/she can see. This is not true. There are three things that happen when you miss an appointment:

1. Your treatment will be delayed, which in some cases can further complicate the condition.
2. The doctor and staff have to wait for the next scheduled patient to arrive before they can resume work.
3. Another patient who needed treatment could not be seen because we did not have enough time to make appointment arrangements.

Because of the above reasons, we REQUIRE 48 hour notice for schedule changes. To help defray the cost of lost appointment time, there is a $75.00 charge per hour for broken appointments.

I have read and understand the office appointment policy

Signature_____Date_____

## Financial Policy:

We understand and appreciate your concerns regarding fees associated with your treatment, and feel that you should have a clear understanding of your financial commitment for services provided. We will be happy to discuss fees anytime prior to treatment. And you as our patient should fully understand our mutual obligations and responsibilities.

## Patients with Insurance:

AS A SERVICE TO YOU, WE WILL COMPLETE AND FILE YOUR INSURANCE CLAIM FORMS FOR COMPLETED TREATMENT. YOUR INSURANCE IS A CONTRACT BETWEEN YOU, YOUR EMPLOYER AND THE INSURANCE COMPANY; WE ARE NOT A PARTY TO THAT CONTRACT. WE MUST EMPHASIZE THAT AS DENTAL CARE PROVIDERS, OUR RELATIONSHIP IS WITH YOU, NOT YOUR INSURANCE COMPANY, THERFORE, ALL CHARGES ARE YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.

PLEASE REMEMBER THAT INSURANCE PLANS ARE USUALLY NOT DESIGNED TO PAY FOR EVERYTHING. WE URGE YOU TO READ YOUR POLICY. WE WILL DO OUR UTMOST TO SEE THAT YOU RECEIVE MAXIMUM BENEFITS WITHIN THE STRUCTURE OF YOUR INSURANCE PLAN.

YOUR PORTION OF PAYMENT (THE COSTS YOUR INSURANCE WILL NOT COVER) IS DUE AT THE TIME OF SERVICE.

## Patients with no insurance:

If you have no insurance, payment for service is due at the time of treatment. To assist you we offer the following options for payment: CASH/CHECK or MASTERCARD, VISA OR DISCOVER.

# Contract to Pay for Dental Services

In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service, unless other arrangements have been made with The Mill Creek Dentist. I/we authorize The Mill Creek Dentist to receive assignment of insurance payments. Any charges in excess of the benefits allowed under the responsible party's insurance plan, I/we understand that I/we are responsible to pay the difference. A finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 30 days.

Authorization to Release Information

The Mill Creek Dentist is hereby authorized to release any dental or incidental information that may be necessary for dental care or processing insurance.

Legal Responsible Party

If the patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain dental care or provide information for processing insurance.

By signing your name you are agreeing to this patient registration contract and acknowledging our financial policy. I also attest that all patient, spouse, health and dental information provided is accurate.

Signature: _____ Date: _____