TIME 01:36 PM

DATE 8/28/2019

PATIENT REGISTRATION

ID: Chart ID:

First Name: Last Name: Middle Initial:

Patient Is: ☐ Policy Holder ☐ Responsible Party Preferred Name:

Responsible Party (if someone other than the patient)

First Name: Last Name: Middle Initial:

Address: Address 2:

City, State, Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Birth Date: Soc Sec: Drivers Lic:

☐ Responsible Party is also a Policy Holder for Patient ☐ Primary Insurance Policy Holder ☐ Secondary Insurance Policy Holder

Patient Information

Address: Address 2:

City: State / Zip: Pager:

Home Phone: Work Phone: Ext: Cellular:

Sex: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Birth Date: Age: Soc Sec: Drivers Lic:

E-mail: ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

Student Status: ☐ Full Time ☐ Part Time

Medicaid ID: Pref. Dentist:

Employer ID: Pref. Pharmacy:

Carrier ID: Pref. Hyg:

Section 3

Referred By:

Heard about us from?

Emergency Contact

Emergency Contact #

Primary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Secondary Insurance Information

Name of Insured: Relationship to Insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Soc. Sec: Insured Birth Date:

Employer: Ins. Company:

Address: Address:

Address 2: Address 2:

City, State, Zip: City, State, Zip:

Rem. Benefits: Rem. Deduct:

Time 1:37 PM

Andersen Dental Center

Patient Medical History Updated 10-6-16

Date 8/28/2019

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

General Single Questions

Are you under a physician's care now?	○ Yes ○ No	If yes	
Have you ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Have you ever had a serious head or neck injury?	○ Yes ○ No	If yes	
Are you taking any medications, pills, or drugs?	○ Yes ○ No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	○ Yes ○ No	If yes	
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	○ Yes ○ No	If yes	
Are you on a special diet?	○ Yes ○ No	If yes	
Do you use tobacco? If yes, how much?	○ Yes ○ No	If yes	
Do you or your spouse snore?	○ Yes ○ No	If yes	
How often do you brush?		Comment	
How often do you floss?		Comment	
Date of last dental visit		Comment	
Date of last dental x-rays		Comment	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Do you use controlled substances? ○ Yes ○ No If yes

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

☐ AIDS/HIV Positive
☐ Diabetes
☐ Hepatitis B or C
☐ Arthritis/Gout
☐ Artificial Heart Valve
☐ Artificial Joint
☐ Fainting Spells/Dizziness
☐ Frequent Cough
☐ Stroke
☐ Cancer
☐ Chemotherapy
☐ Chest Pains
☐ Cold Sores/Fever Blisters
☐ Heart Pacemaker
☐ Cortisone Medicine
☐ Hepatitis A
☐ Easily Winded
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Kidney Problems
☐ Bruise Easily
☐ Glaucoma
☐ Hay Fever
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Ulcers
☐ Radiation Treatments
☐ Anaphylaxis
☐ Rheumatic Fever
☐ High Cholesterol
☐ Hives or Rash
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Blood Transfusion
☐ Low Blood Pressure
☐ Lung Disease
☐ Mitral Valve Prolapse
☐ Osteoporosis
☐ Pain in Jaw Joints
☐ Heart Trouble/Disease
☐ Alzheimer's Disease
☐ Drug Addiction
☐ High Blood Pressure
☐ Scarlet Fever
☐ Shingles
☐ Asthma
☐ Blood Disease
☐ Stomach/Intestinal Disease
☐ Swelling of Limbs
☐ Thyroid Disease
☐ Tonsillitis
☐ Tuberculosis
☐ Tumors or Growths
☐ Psychiatric Care

Have you ever had any serious illness not listed above? ○ Yes ○ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X _____ Date: _____

Financial Responsibility

Dr. Andersen and staff are committed to giving you superior care and we want you to feel as comfortable as possible throughout your treatment. This includes understanding your treatment plan, as well as our financial policy. Carefully read the following, then let us know if you have any further questions.

- As a courtesy to our patients we will bill your insurance, however, the responsibility for payment will remain with you. In order for us to bill your insurance you must supply us with complete information about your plan. Including any necessary forms, group numbers, phone numbers, member ID numbers and addresses. If your insurance provider has not paid within 60 days of treatment, you will need to pay your account in full to Andersen Dental Center. We will then reimburse you if and when your plan has paid. Andersen Dental Center can make no guarantees of the benefit plans estimate of payment. This office does not absolve the patient of full responsibility for the fees in full for treatment rendered.
- Patients who do not participate with a dental plan must provide our office with your Social Security Number and Driver's License unless your total charge is paid in cash at the time of service. Treatment may be postponed if the above information is not furnished by the patient or the responsible party.
- Payment is expected at time of services rendered.
- Our fees are on file with Washington Dental Services. We accept VISA, MasterCard, Discover, AmEx, Care Credit, Cash and Check. All accounts over 60 days will be assessed 1.5% interest per month (18% APR). There will be a $25 fee charged for all returned checks.
- If unable to keep your appointment, kindly provide 48 hours-notice. For appointments missed or cancelled under the 48 hour-notice, we reserve the right to charge a $50 cancellation/no show fee.
- If an account is over 120 days past due it may be sent to pre-collection status with a 3rd party collection agency. If account is not paid during pre-collection status, the account will turn over to collections.
- For appointments with the patient portion greater than $5000, a deposit equaling 50% of the patient portion will be collected at time of scheduling to reserve your appointment time.

I understand the financial policy as written above. I acknowledge that I am financially responsible for all fees. I hereby authorize Andersen Dental Center to release all information to secure payment.

_____ _____

Patient Signature (or responsible person, if patient is a minor) Date

Consent for Comprehensive Exam and Prophylaxis (Dental Cleaning)

Exam and Cleaning: Regular exams and cleanings play an important role in proper dental health. They allow the dentist to screen for dental caries, gingival and/or periodontal issues or orthodontic issues. I understand that if I choose not to maintain regular check-ups and/or cleanings, this decision may result in decay, pain, infection and/or orthodontic or periodontal problems. Depending on your periodontal exam results, you may need a more focused cleaning visit (deep cleaning). You may need to be rescheduled to allow enough time for your cleaning.

Initial_____

X-Rays: X-rays are used as an important diagnostic tool for the dentist. How often x-rays is taken depends on the age, risk for disease, and signs and symptoms of the patient. Many diseases of the teeth and surrounding tissues cannot be seen when your dentist examines your mouth visually. An X-ray may reveal the presence of small cavities between the teeth, infections in the bone, abscesses, cysts, developmental abnormalities and some type of tumors. It is in your (or your child's) best interest to be periodically screened with the use of all diagnostic x-rays. Risks of not taking-rays include but are not limited to: a failure to diagnose and treat, risk your overall oral health and possible infection. Risks from radiation exposure have been significantly reduced by improvements in technology; we have the most up to date digital/low dose exposure equipment available. If you plan on using existing (up to date), x-rays from another provider, you must have them with you for this visit (or have them sent to our office prior.) If they are not here, we must take new x-rays. If they are not here, we must take new x-rays or reschedule your visit.

Initial_____

Treatment Discussion Visit: After reviewing the findings from your comprehensive examination, if extensive treatment is needed or the doctor needs time to review the diagnostics prior to presenting findings, you may be advised to return for a complimentary treatment discussion visit. A treatment discussion visit will be dedicated time with one of the doctor's assistants and the doctor. I understand that dentistry is not an exact science; therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and to ask questions. My questions have been answered to my satisfaction.

Initial_____

Acknowledgement of Receipt of HIPPA Notice of Privacy Practices

Andersen Dental Center
2415 NE 134th Street Ste 307
Vancouver, WA 98686

Acknowledgement

I, _____, hereby acknowledge that I have received and reviewed a copy Andersen Dental Center's *HIPPA Notice of Privacy Practices.*

I understand that Andersen Dental Center's *HIPPA Notice of Privacy Practices* may change periodically and that I am entitled to receive a copy of Andersen Dental Center's *revised HIPPA Notice of Privacy Practices* upon request.

I understand that if I have questions about Andersen Dental Center's *HIPPA Notice of Privacy Practices* I may contact the Office Administrator.

I understand that it is my right to refuse to sign this acknowledgement should I so choose and that Andersen Dental Center will not refuse treatment to me if I refuse to sign this acknowledgement.

I further understand that I may contact the Secretary of the U. S. Department of Health and Human Services should I have concerns regarding Andersen Dental Center's privacy policies and procedures. For information on how to contact the U.S. Department of Health and Human Services, lease ask the Office Administrator for assistance.

_____ _____
Patient Signature Date

_____ _____
Signature of personal representative Print name and relationship to patient

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For Office Use Only

Andersen Dental Center made a good-faith effort to obtain Acknowledgement from the patient noted above, of receipt of its *HIPPA Notice of Privacy Practices.* In spite of these efforts, Andersen Dental Center was unable to obtain a signed Acknowledgement for the following reason(s):

() Refusal to sign Acknowledgement on _____, 20_____
() Communications barrier prohibited us from obtaining a signed Acknowledgement
() An emergency situation prohibited us from obtaining a signed Acknowledgement

Received by: _____ Date:_____