Kitsap Family Dentistry

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Mailing Address: _____

Home or Cell Phone: _____ Email: _____ Social Security #: _____

DENTAL INSURANCE

Please make sure your insurance information is accurate and complete or we may not be able to bill your insurance and you may be responsible for the entire cost of dental services.

Subscriber's Name: _____ Date of Birth: _____ Subscriber's ID: _____

Subscriber's Employer: _____ Name of Insurance Plan: _____

Insurance Company: _____ Insurance Phone: _____ Do you have secondary insurance? Yes No

HEALTH HISTORY

Please fill out this health history completely to help us tailor your dental treatment to your needs. If you need more room, we can give you more paper.

Yes No Do you have a physician? If so, give name: _____

Yes No Have you been hospitalized? If so, list when and why: _____

Yes No Do you have any drug allergies (Penicillin, Codeine, Latex, etc.)? If so, please list: _____

Yes No Do you take medications? If so, please list: _____

Yes No Artificial joints (hip, knee, etc.)
Yes No High blood pressure / Angina / Arrhythmias
Yes No Heart disease / Heart attack (When? _____)
Yes No Artificial heart valve / Defibrillator
Yes No Bleeding disorders / Prolonged bleeding
Yes No Anemia / Leukemia / Blood dyscrasias
Yes No Stroke / Aneurysm
Yes No Seizures
Yes No Hepatitis / Liver disease / Kidney problems
Yes No Arthritis / Lupus
Yes No Anxiety / Depression / Psychiatric treatment
Yes No Tobacco use
Yes No Dental anxiety

Yes No Ulcers / Stomach problems
Yes No Osteoporosis / Bone disease
Yes No Diabetes (Type: _____)
Yes No Thyroid / Adrenal problems
Yes No Cancer / Tumors (Type: _____)
Yes No Chemotherapy / Radiation treatment
Yes No Sinus problems / Ear problems / TMJ disorder
Yes No HIV / AIDS / Immunosuppression
Yes No Asthma / Tuberculosis / Lung disease
Yes No Sleep Apnea
Yes No Drug / Alcohol abuse
Yes No Nursing / Pregnant (Due date: _____)

Yes No Any other medical problems? If so, please describe: _____

To the best of my knowledge, I have filled out this Health History Form completely and accurately.

Patient / Guardian Signature: _____ Date: _____

Kitsap Family Dentistry

Patient Name: _____

_____ Financial Agreement for Dental Services:

please initial

For patients with dental insurance, the estimated portion not covered by insurance is due at time of treatment. We are happy to submit claims to your insurance and help you receive the benefits due to you, but we can't accept responsibility for collecting your claim or for negotiating disputed claims.

For patients without dental insurance, payment for dental services is due at time of treatment.

_____ Appointments and Cancellations:

please initial

If you must change an appointment, please give us at least 24-hour prior notice. This courtesy makes it possible to give your reserved room and time to another patient who would like it. There is a **$50** charge for not showing up for scheduled appointments. Repeated cancellations or missed appointments may result in loss of future appointment privileges.

_____ Statement of Privacy Practices – Acknowledgement:

please initial

We keep a record of health care services we provide you. You may ask to see and copy that record. We will not disclose your record to others unless you direct us to do so or unless the law authorized or compels us to do so. You may see your record or get more information about it by contacting our office.

Our **Statement of Privacy Practices** describes in more detail how your health information may be used and disclosed and how you can access your information. You are entitled to a copy of the Statement of Privacy Practices. The Statement of Privacy Practices is also posted in the facility.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I specifically authorized disclosure of my protected health care information to the persons indicated below.

ANY MEMBER OF MY FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY):		YES		NO

I understand and agree to these office policies and I have received or been offered a copy of the Statement of Privacy Practices.

_____

Patient or legally authorized individual signature Date