Kent Dental Arts

www.kentdentalarts.com
24722 104th Ave.SE #101 • Kent, WA 98030-5322
frontdesk@kentdentalarts.com
(253)852-9088

Welcome to our Practice

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____* _____* _____ _____
Last | First | MI | Preferred Name

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

Birth Date:* _____ **SS#:** ___-__-____ **Prev. Visit:** _____

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

Phone: _____* _____ _____ _____ _____ _____
Home | Mobile | Work | Ext | Fax | Other

Address: _____* _____
Address 1 | Address 2

_____* _____* ___-____*
City | State | Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 | Address 2

_____ _____ ___-____
City | State | Zip Code

Whom may we thank for referring you to our practice?

_____

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

_____

_____

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer 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 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 changes whether or not paid by insurance.

Secondary Dental Insurance

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer 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 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 changes whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- ☐ Acid Reflux
- ☐ Asthma
- ☐ Cancer/Tumor
- ☐ COPD
- ☐ Diabetes
- ☐ EyeConditionGlaucoma
- ☐ Heart Condition
- ☐ Herpes
- ☐ History of Smoking
- ☐ Latex Allergy
- ☐ MitralValve Prolapse
- ☐ Osteoporosis
- ☐ Pulmonary Disease
- ☐ Sinus Problems
- ☐ Sulfa Allergy
- ☐ Ulcers
- ☐ Alcohol Use
- ☐ Auto Immune Disorder
- ☐ Chemotherapy
- ☐ Currently Smoking
- ☐ Dizziness/Fainting
- ☐ Hard of Hearing
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ HIV/Aids
- ☐ Liver Disease
- ☐ Nervous/Anxiety
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Sleep Disorder
- ☐ Thyroid Disorder
- ☐ Unlisted Allergy
- ☐ Arthritis
- ☐ BloodDisorder/Anemia
- ☐ Chewing Tobacco
- ☐ Dental PREMEDICATION
- ☐ Emphysema
- ☐ Hay Fever/Allergies
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Hypoglycemia
- ☐ Medication Allergy
- ☐ NeurologicalDisorder
- ☐ Penicillin Allergy
- ☐ Recreational Drugs
- ☐ STD
- ☐ Tuberculosis
- ☐ Artificial Joints
- ☐ BloodThinnerCoumadin
- ☐ Codeine Allergy
- ☐ Depression
- ☐ Epilepsy/Seizures
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ History of Addiction
- ☐ Kidney Disease
- ☐ Mental Disorders
- ☐ NSAID Allergy
- ☐ Pregnancy
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Tumors/Non-cancerous

ALLERGIES

Check any of the following that you have an allergy to or had a reaction to:

- ☐ Local Anesthetic (numbing agent)
- ☐ Penicillin/Amoxicillin
- ☐ Tetracycline
- ☐ Erythromycin/Clindamycin
- ☐ Other Antibiotics
- ☐ Sedatives or Sleeping Pills
- ☐ Codeine or other Narcotics
- ☐ Sulfa Drugs
- ☐ Aspirin/Ibuprofen/Naproxen
- ☐ Other Medications
- ☐ MSG/Sulfates
- ☐ Latex

Please list ANY other allergies not listed:

_____

_____

If any conditions or alerts selected so far needs further clarification, please describe below:

_____

_____

MEDICATION

Please list ALL medications and supplements your are currently taking and the needed use for each medication:

_____

_____

_____

_____

DENTAL PRE-MEDICATION

Do you have a medical condition (i.e. heart murmur, artifical joint) that requires antibiotic pre-medications for your dental visits? *

◯ Yes ◯ No

If YES,what do you take and what dose?

_____

_____

Please check ALL that apply to you:

- ☐ Urinate more than 6 times per day?
- ☐ Ever been hospitalized (illness or injury)?
- ☐ Aware of any unexpected weight changes?
- ☐ Taking large does of aspirin?
- ☐ Taking cortisone (steroids)?
- ☐ Use an inhaler?
- ☐ Taking dietary supplements?
- ☐ Subject to frequent headaches?
- ☐ Taken medications for weight control (i.e. fen-phen)?
- ☐ Taking insulin or similar drug?
- ☐ Taking nitroglycerine or similar medication?
- ☐ Presently being treated for any other illness?

If any condition selected above needs further clarification, please describe below:

_____

_____

_____

Women Only:

- ☐ There is a possibilty that I am pregnant
- ☐ I am pregnant
- ☐ I am nursing
- ☐ I am taking birth control pills

What is your estimate of your general health?

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Poor

Name of physician and their specialty:

Most recent physical exam and purpose:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

_____

_____

☐ *By checking this box, I acknowledge that above information is correct and I understand it is my responsibility to inform the office of any changes in my health as soon as possible.

Dental Information

How would you rate the condition of your mouth?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Previous dentist name and how long have you been a patient there:

_____

_____

Date of most recent dental exam: _____ **Date of most recent dental x-rays:** _____

I routinely see my dentist every:

☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

What is your immediate concern?

_____

_____

Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) _____

Personal History - Check all that apply:

☐ Had an unfavorable dental experience
☐ Had complications from past dental treatment
☐ Had trouble getting numb
☐ Had any reactions to local anesthetic
☐ Have/Had braces, orthodontic treatment
☐ Had your bite adjusted
☐ Had any teeth removed

Smile Characteristics - Check all that apply:

☐ Is there anything about the appearance of your teeth that you would like to change?
☐ Have you ever whitened (bleached) your teeth?
☐ Have you felt uncomfortable or self conscious about the appearance of your teeth?
☐ Have you been disappointed with the appearance of previous dental work?

Bite and Jaw Joint, Check all that apply:

☐ You have problems with your jaw joint
☐ You have any problems chewing
☐ Your teeth changed in the last 5 years, become shorter, thinner, or worn
☐ Your teeth crowding or developing spaces
☐ You chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits
☐ You clench your teeth in the daytime or make them sore
☐ You have problems with sleep or wake up with an awareness of your teeth
☐ You wear or have worn a bite appliance

Tooth structure, Check all that apply:

- ☐ Cavities within past 3 years
- ☐ The amount of saliva in your mouth seems too little or you have difficulty swallowing any food
- ☐ You notice or have holes (i.e. pitting, crates) on the biting surface of your teeth
- ☐ Any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth
- ☐ Grooves or notches on your teeth, chipped teeth, or had a toothache or cracked filling
- ☐ Food gets caught between any teeth

Gum and Bone, Check all that apply:

- ☐ Gums bleed when brushing or flossing
- ☐ Treated for gum disease or were told you have lost bone around your teeth
- ☐ Noticed an unpleasant taste or odor in your mouth
- ☐ History of periodontal disease in your family
- ☐ Experienced gum recession
- ☐ Had any teeth become loose on their own (without injury), or have difficulty eating an apple
- ☐ Experienced a burning sensation in your mouth

IF ANY OF THE CHECKED BOXES NEED FURTHER EXPLAINATION, PLEASE DESCRIBE:

_____

_____

_____

Consent for Services and Financial Policy

Thank you for choosing us as your family dental provider. We look forward to providing you with optimal and high quality treatment.

We are happy to offer flexible financial arrangements for your convenience. Financial deposits for the out of pocket portion of treatment are expected the day services are rendered. At least half of your estimated portion will be due the day we start any crownn/bridge work. We also offer financing through Care Credit for balances over $1000.00. We also accept MasterCard, Visa, Debit Cards and Discover for your convenience. Our services are interest free for 90 days.

Once we have examined you, and formulated a treatment plan, we will review all of the treatment and financial options with you before services are rendered.

As a courtesy to our patients, we do our best to verify dental benefits, and bill your dental benefit company for you. We are a preferred provider with Washington Dental Service, Regence blue Shield and Premera Blue Cross. We will help you maximize your insurance benefits to the best of our ability. Your estimated patient portion for services are based upon the information provided by your benefit company and may not be the exact amount of your benefit. Any balance not covered by your benefits is your responsibly. We ask that all balances are paid in full within 90 days from the date of service. Any balances over 90 days will accrue 1.5% interest.

Dental benefits are a contract between your employer and your dental benefit company. The benefits that you will receive are based on the terms of the contract that were negotiated between your employer and the dental benefit company. Some plans exclude some services, while other plans cover more extensive treatment.

Our treatment plans are based on each patients needs, and not on whether treatment is covered by a dental plan. However, we will work with your benefit company to obtain the maximum benefit coverage for your recommended dental treatment.

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

Cancellation Policy

When you schedule an appointment, this time is reserved especially for you. A considerable about of planning and preparation goes into each patient's appointment time. Out of courtesy to our other dental patients and the dental staff and to avoid a $75.00 fee, we require 2 business days notice for any appointment changes.

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

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,

☐ * **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. I 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 PATIENT 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.**

Signature _____ **Date** _____

Response Date: _____