

Kent Dental Arts

www.kentdentalarts.com
24722 104th Ave. SE #101 • Kent, WA 98030-5322

frontdesk@kentdentalarts.com
(253)852-9088

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: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ Best time to call: _____
Home Mobile Work Ext

Address: _____
Address 1 Address 2
City State Zip Code

Employer Name: _____

My insurance information has changed: * Yes No

SKIP, IF YOUR INSURANCE INFORMATION HAS NOT CHANGED

Primary Dental Insurance

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

Secondary Dental Insurance

Name of Insured: _____
Last First MI

Patient's relationship to insured: Self Spouse Child Other

Insurance Plan Name: _____

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.

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

ALLERGIES

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

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Local Anesthetic (numbing agent) | <input type="checkbox"/> Penicillin/Amoxicillin | <input type="checkbox"/> Tetracycline | <input type="checkbox"/> Erythromycin/Clindamycin |
| <input type="checkbox"/> Other Antibiotics | <input type="checkbox"/> Sedatives or Sleeping Pills | <input type="checkbox"/> Codeine or other Narcotics | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Aspirin/Ibuprofen/Naproxen | <input type="checkbox"/> Other Medications | <input type="checkbox"/> MSG/Sulfates | <input type="checkbox"/> Latex |

Please list ANY other allergies not listed:

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

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, artificial 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:

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

If any conditions selected above need further clarification, please describe below:

Women Only:

- There is a possibility 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 your physician and their specialty:

Most recent physical exam and purpose:

Please describe ANY medical changes since your last visit with us.

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

*By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and had responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes.

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 crown/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 amount 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: _____

Response Date: _____