



Welcome to Olympia Dental Center

1840 Barnes Blvd SW, Tumwater, WA 98512 360.943.4300

Today's Date_____

Name (First, MI, Last) _____ Preferred Name_____

Sex: (circle one) M/F

Marital Status: (circle one) Married/ Single/ Child

Social Security Number _____ - _____ - _____ DOB:_____

Mailing address_____ City_____

State_____ Zip code _____ Email address _____

Cell phone_____ Work phone_____ Home Phone_____

Employer_____

Dental Ins Co_____ Subscriber's ID #_____ Group #_____

If you are NOT the Dental INS subscriber; list subscriber's Name, DOB and Employer on the line below

Emergency Contact Name_____ Cell phone_____ Relationship_____

Whom may we thank for referring you? _____

With your *prior* permission may we post or share pictures of you on social media or on our website? No/Yes

DENTAL HEALTH HISTORY

Approximate date of last dental treatment _____

Do you have toothache symptom(s) now? _____ No/Yes

If yes, please *circle* any of the following toothache symptoms that apply to you currently; hot sensitive, cold sensitive, sweet sensitive, sharp pain when you bite, dull ache when you wake up?

Have you had problems with prior dental treatment? _____ No/Yes

Do your gums ever feel tender, swollen or bleed? _____ No/Yes

Have you ever been instructed to take a pre-med for dental treatment? _____ No/Yes

Do you have frequent headaches? _____ No/Yes

Do you have jaw pain? _____ No/Yes

Has your jaw ever locked open or closed? _____ No/Yes

Have you ever had Botox injections for Migraines/TMJ/TMD pain? _____ No/Yes

Have you ever had jaw or head trauma from an accident? _____ No/Yes

Do you have neck, back or hip pain? _____ No/Yes

Do you clench or grind your teeth? _____ No/Yes

Do you have dry mouth? _____ No/Yes

Are you a mouth breather while you sleep? _____ No/Yes

Have you ever been diagnosed with sleep Apnea? _____ No/Yes

Do you wear a sleep appliance? _____ No/Yes

Do you snore? _____ No/Yes

Have you had orthodontic treatment? _____ No/Yes

Are you interested in whitening your teeth or changing your smile in any way? _____ No/Yes

Dr's Notes:

MEDICAL HEALTH HISTORY

Who is your physician? _____ Physician's phone number _____

Approximate date of last medical exam _____ Is your general health good? No/Yes

Circle the appropriate answer (if you answer yes to any of the following questions please explain in the space provided)

Has there been a change in your health within the last year? No/Yes

Is a physician treating you now? No/Yes

Have you been hospitalized or had a serious illness in the last three years? _____ No/Yes

Are you interested in Botox injections for migraines, TMD or cosmetic reasons? _____ No/Yes

CURRENT BLOOD PRESSURE ____/____ (to be filled out by office personnel) Date _____

Conditions: Circle Yes OR No to EACH of the following. If you have any history of the following, please explain or give approximate date of diagnosis.

Anemia _____ No/Yes

Angina _____ No/Yes

Arthritis _____ No/Yes

Artificial Joint(s) _____ No/Yes

If yes, list joint(s) and approximate date of surgery _____

Asthma _____ No/Yes

Blood Disease _____ No/Yes

Bruise/Bleed easily _____ No/Yes

Cancer/Chemo _____ No/Yes

Diabetes _____ No/Yes

Epilepsy _____ No/Yes

Fainting _____ No/Yes

Gastric Reflux _____ No/Yes

Head Injuries _____ No/Yes

Heart Disease/Attack _____ No/Yes

Heart Murmur _____ No/Yes

Hepatitis (A, B or C) _____ No/Yes

High Blood Pressure _____ No/Yes

HIV/AIDS _____ No/Yes

Kidney Disease _____ No/Yes

Liver Disease _____ No/Yes

Mental Disorders (i.e., depression or anxiety) _____

No/Yes

Please list any conditions not listed that you have a history of: _____

Mitro Valve Prolapse _____ No/Yes

Nervous System Disorders (i.e.; Autoimmune disorders, ADHD, Cerebral Palsy, Epilepsy, etc.) _____

_____ No/Yes

Osteoporosis _____ No/Yes

If yes, list history of medication as well as current medication for treatment _____

Pacemaker _____ No/Yes

Pregnancy (only list if you are currently pregnant) _____ No/Yes

Radiation/Chemo Treatment _____ No/Yes

Respiratory Problems _____ No/Yes

Rheumatic Fever _____ No/Yes

Rheumatism _____ No/Yes

Sleep Apnea _____ No/Yes

Stomach Problems _____ No/Yes

Stroke _____ No/Yes

Thyroid Disease _____ No/Yes

TMJ/TMD _____ No/Yes

Tumors _____ No/Yes

Ulcers _____ No/Yes

Venereal Disease _____ No/Yes

Allergies: Circle Yes or No if you have any history of an allergic reaction to any of the following. Please list approximate date allergy manifested

Amoxicillin _____ No/Yes

Aspirin _____ No/Yes

Benadryl _____ No/Yes

Codeine/Vico _____ No/Yes

Dental Anesthetics _____ No/Yes

Erythromycin _____ No/Yes

Latex _____ No/Yes

Sulfa _____ No/Yes

Please list any other known allergies _____

Medications:

Please list prescription medications you are **currently** taking:

If you currently take more than 7 prescription medications, please provide a current printed list to scan into your chart

Medication: _____	Dosage: _____	Reason: _____
Medication: _____	Dosage: _____	Reason: _____
Medication: _____	Dosage: _____	Reason: _____
Medication: _____	Dosage: _____	Reason: _____
Medication: _____	Dosage: _____	Reason: _____
Medication: _____	Dosage: _____	Reason: _____
Medication: _____	Dosage: _____	Reason: _____

Please list any over-the-counter medicines or natural remedies you are currently taking: _____

Do you have a **history** with OR are you currently taking any of the following (circle one):

If you have history of any of the following, please give approximate date(s)

Recreational drugs: Past/Present/None
Viagra/Cialis (ED meds): Past/Present/None
Tobacco in any form: Past/Present/None
Birth control pills: Past/Present/None
Bisphosphonates: Past/Present/None

Warfarin: Past/Present/None
Fish Oil: Past/Present/None
Blood Thinners: Past/Present/None
Aspirin: Past/Present/None
Pain medications: Past/Present/None

To the best of my knowledge, I have answered every question completely and accurately. I will inform you of any change in my health and/or medication at each appointment.

Patient or guardian's signature _____ **Date** _____

Witness/Dr. signature _____

Olympia Dental Center Office Financial Policy

Thank you for choosing our office as your dental provider. We are committed to providing you with the highest quality dental care, so that you may attain optimum oral health. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment.

- We will go over expected costs of treatment before proceeding
- In an effort to be more cost effective to our patients we require payment at the time of service
- Our office accepts cash, personal checks, MasterCard, Visa, Discover and CareCredit
- Some of our established patients may be offered "50/25/25" payment plan on most treatments with provided bank or credit card information for auto payment(s) set-up
- Additional \$45 fee will be applied for returned checks or declined auto payments
- All account balances over 90 days are subject to a late fee and will be sent to collections.
- In order to provide the best service to all our patients, we require at least a 48-hour notice to cancel or re-schedule an appointment. A \$78 charge may be assessed for missed or short notice cancelations. Multiple failed appointments may result in being dismissed from the dental practice

All insured patients: We will provide an insurance estimate to you; **it is not a guarantee that your insurance will pay exactly as estimated.** Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles and maximums. **Contact your insurance company for a detail of your benefits.** Your estimated portion is due at time of service.

As a courtesy we bill your insurance company for you however; you are responsible for giving us up to date insurance information at each appointment. Insurance payments are ordinarily received 5-30 days from the time of filing a claim. If your insurance company has not made their payment within 60 days, we will resubmit the claim. We will submit up to 2 claims per procedure without cost to you. If the provided insurance company denies a claim 3 times or 60 days go by without response; our office will notify you, give you the opportunity to call them and submit the claim personally. If you prefer our administration submit additional insurance claims for the same procedure each additional submission may incur a \$35 service fee.

You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. **All charges you incur are your responsibility, regardless of your insurance coverage.** We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Your insurance policy is a contract between you and your insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid and in line with any contracted INS companies we are partnered with. Our office will not, however, enter a dispute with your insurance company over any claim. If payment is not received or your claim is denied, after reasonable attempts you will be responsible for paying the full amount at that time.

I authorize my insurance company to pay my dental benefits directly to my dental office. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I am aware that my INS carrier may pay less than the estimated amount and that I am financially responsible for any account balance. Consent for insured and non-insured patients: Minors accompanied by parent or legal guardian: The parent or legal guardian accompanying a minor, who has consented to treatment, is responsible for payment at time of service.

Unaccompanied Minors: The parent or legal guardian is responsible for full payment at time of service. Treatment consents and payment arrangements with the parent or legal guardian must be made prior to appointment or nonemergency treatment may be denied.

I agree to pay for all services provided. I acknowledge and accept that it is my personal responsibility for payment in full for billed charges. I acknowledge failure to pay my financial obligations to Olympia Dental Center may result in the referral of account(s) to a professional collection agency and/or additional interest, late fees, and rebilling fees. I consent to any professional collection agency to obtain a copy of my credit report or any other publicly available data related to my ability to pay. In the event of any dispute regarding payment, I agree to pay all collection costs or fees including but not limited to interest at the highest rate allowable under law and attorney's fees in the event legal action is taken. I grant permission and consent to us, our assignees and third party collection agents to (1) contact you by telephone at any telephone number associated with you, including wireless numbers; (2) leave answering machine and voicemail messages for you, and include in any such messages info required by law and/or regarding amounts owed by you; (3) to send you text messages; (4) to use prerecorded/artificial voice messages and/or auto dialing device in communications made to you or related to your account.

I have read, understand and agree to the above terms and conditions.

Patient (or guardian) signature _____ Date _____

Witness Signature _____

HIPAA Compliance Patient Consent Form

I acknowledge that I have had an opportunity to read and obtain a copy of the Statement of Privacy Practices for the office of Olympia Dental Center. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent (*located in office lobby*). The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations. By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, anonymous publication or healthcare operations.
- Olympia Dental Center reserves the right to change the privacy policy as allowed by law.
- The patient has the right to revoke this consent in writing at any time and all disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. I understand that the default answer is "NO" without indicating "YES" in answer to each individual question, personal protected health information cannot be shared with anyone unless otherwise allowed by HIPAA rules.

May we discuss your medical condition with your spouse? YES/ NO

May we discuss your medical condition with your immediate family: (i.e. children, siblings, etc) YES/NO

May we discuss your medical condition with your extended family: (i.e. parents, grandchildren, etc) YES/NO

May we discuss your medical condition with any other non-relative(s) YES/NO If YES, please list name(s):

May we discuss your medical condition with other healthcare providers; such as previous dental providers or physicians regarding medications, x-rays or treatments? YES/NO

Please list medical and dental professional(s) that we may discuss your treatment, ask for or give previous x-rays to, sleep study information, medications or chart records with:

May we leave a voicemail to confirm appointments on any of your given phone numbers? YES/ NO

May we email you concerning treatment estimated fees or to confirm appointments? YES/ NO

This consent was signed by: _____ (PRINT NAME PLEASE)

Signature: _____ **Date:** _____

Witness: _____ **Date:** _____

If acknowledgement was not obtained please provide reason (Circle one) Need more time to review statement/Want to consult with another person before signing/Physically unable to sign/Other:
