PATIENT INFORMATION / HEALTH HISTORY

Welcome to the office of Denture Services Northwest, Inc. We appreciate the confidence placed with us to provide denture services to you. To assist us in treating you, please complete the entire form.
All information will be kept confidential. **PLEASE PRINT.**

Date____________________

Patient Name______________________________________ *Date of Birth* _________________Sex ______Age ______

Home Address ___________________________________City __________________State __________Zip __________

Home Phone __________________________Work/Cell_________________________SS#________________________

Is patient a child? No/ Yes. If yes parent or guardian name____

PERSON RESPONSIBLE FOR PAYMENT: (PLEASE CIRCLE ONE) Patient Spouse Parent Guardian

Name_____________________________________SS#__________________________Relation______________________

Billing Address (IF DIFFERENT) ____________________________City _______________State ________Zip______________

INSURANCE INFORMATION
IF YOU DO NOT HAVE INSURANCE PLEASE LEAVE THIS SECTION BLANK

Subscriber Name ____________________________________Employer Name_______________________________________

SS#_______________________ Date of Birth______________________ Insurance Name______________________________

Insurance Phone Number _________________________Group #_________________ ID # ___________________________

DO YOU HAVE A SECONDARY INSURANCE? IF YES, Subscriber Name____

SS# ___________________________Date of Birth _________________Employer___________________________________

Secondary Insurance Name __________________________Insurance Phone _____________________Group #______________

Medical Doctor Name & Phone #____Last Visit____________________

Previous Dentist Name and Phone #____Last Visit_____________________

Emergency # not living with you. Name & Phone #____

Who may we thank for referring you to our office? ____

I hereby authorize payment directly to Denture Services Northwest of the group insurance benefits otherwise payable to me. I understand that there will be finance charge of 12% APR charged to all accounts with a balance after 90 days. I acknowledge that I am responsible for this account and upon payment defaults beyond agreed upon terms I will be turned over to collections. This office charges a $30.00 fee for appointments broken without a **24 hour** notice.
I understand that I am utilizing the services of a denturist and not a dentist. I understand that a denturist does not diagnose, evaluate or treat any malfunction of the oral cavity and I should see a dentist or physician if such services are required. I also authorize Denture services Northwest, Inc. to release any information required by them to my insurance companies, and other related health care providers. The information I have provided for this chart is true and correct to the best of my knowledge.

____ ________________________

Signature **Date**

PLEASE MARK AN "X" NEXT TO ANY QUESTIONS THAT APPLY TO YOU.

___ Are you apprehensive about dental treatment?
___ Have you had any unpleasant dental experiences?
___ Are you aware of a bad odor or taste in your mouth
___ Have you experienced any reaction to dental Anesthetic?
___ Do you have a preference for NO anesthetic?
___ Have you experience unusual dryness of the mouth?
___ Do you gag easy
___ Does food catch between your teeth?
___ Do you have difficulty in chewing food?
___ Do your gums bleed easily
___ Have you ever noticed slow healing sores in or about your mouth?
___ Are your teeth sensitive?
___ Do you feel pain when your teeth come in contact with:
    ___ Hot or cold foods?
    ___ Hot of cold liquids?
    ___ Sour?
    ___ Sweets?
___ Do you take fluoride supplements?
___ Are you dissatisfied with the appearance of you teeth?
___ Do you want complete dental care?
___ Does your jaw make a noise so that it bothers you?
___ Do you clench or grind your jaws frequently?
___ Does your jaw feel tired?
___ Do you have temporomandibular (jaw) disorder (TMJ, TMD)?
___ Have you had a blow or trauma to your jaw?
___ Have you had orthodontic treatment?

Medical Health history, please check any that apply.
___ Do you have a current health problem?
___ If so, are you currently under care of a physician?
___ Have you been hospitalized within the 5 years?
___ Have you had a serious illness in the last 5 years?
___ Do you have any of the following:
    ___ Angina/chest pains? Frequency______
    ___ Heart attack date _________?
    ___ Heart surgery date ________?
    ___ Pacemaker date __________?
    ___ Mitral valve defect _______?
    ___ Rheumatic fever _________?
    ___ Heart murmur?
    ___ High blood pressure?
    ___ Congenital heart defect?
    ___ Stroke date _________?
    ___ Bypass?
    ___ Atheriosclerosis?
    ___ Prosthetic heart valve?
    ___ Other?_________________

Please list any medications you have taken in the last year

___ Hepatitis, type____ date _______?
___ Anemia?
___ Venereal Disease (VD)?
___ AID or ARC?
___ HIV Positive?
___ Herpes?
___ Prolonged Bleeding?
___ Athritis?
___ Artificial Joint, limb, or implant?
___ Hypoglycemia?
___ Chronic head, neck, or back pain?
___ Smoker how long _____?
___ Alcoholism and/or drug addiction
___ Tuberculosis date _____?
___ Leukemia or Cancer?
___ Stomach or intestinal ulcers?
___ Sinus trouble or hay-fever?
___ Liver disease or jaundice?
___ Kidney disease?
___ Psychiatric treatment?
___ Epilepsy?
___ Hypothyroidism or Hyperthyroidism?
___ Limitation to your activities?
___ Glaucoma?
___ Persistent cough?
___ Emphysema or Asthma?
___ Diabetes?
___ Blood transfusion?

Are you allergic to, or have you had an unusual reaction to any of the following? Please circle

ASRPRIN PENCILLIN EYTHROMYCIN METALS LATEX

CODIENE FLUORIDE SULFA LOCAL ANESTHETIC

Any other? Please list ____________________________________.
Have you had surgery, radiation or other treatment for a tumor or growth
Yes_____ **No** _____
For women; Are you pregnant? (due date________)

What is your immediate concern?:_______________________

____

The above medical information is correct to the best of my knowledge. If I have changes in my health or medications, I will inform Denture Services Northwest at my next appointment. I grant my permission for my physician to be in contact for detail and advice. I further authorize the taking of radiographs, photographs, or other diagnostic measures appropriate for a thorough evaluation. I also give authorization for treatment by Denture Services Northwest, Inc I understand the responsibility for payment for services provided in this office for myself and/or dependents is mine, due and payable at the time services are rendered, unless arrangements have been made.

____
SIGNATURE DATE

Acknowledgement of Privacy Policies

DENTURE SERVICES NORTHWEST, INC.
7424 Bridgeport Way West, Suite 204
Lakewood, WA 98499
(253)565-4435 FAX (253)565-4661

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ❑ Obtain payment from third-party payers for my health care services
- ❑ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

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For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

- -

Dependent family members also covered by this acknowledgement:

____

____

Patient Name: ____

Relationship to Patient: ____

____

Signature Date

FINANCIAL AND CANCELLATION POLICIES

PLEASE READ THIS CAREFULLY!!!!

If you have any questions regarding these policies, please just ask, it is our priority to make sure all of our patients have a clear understanding.

FINANCIAL POLICY OF DENTURE SERVICES NORTHWEST, INC.

Please be advised that payment is due IN FULL at the INITIAL time of service. Unless other arrangement have been made, We generally do not bill insurance; however, as a courtesy to our patients, we will gladly supply you with an insurance statement to submit to your insurance company. If you are eligible for benefits, your insurance company may reimburse you for some or all of your charges. Please keep in mind that your insurance policy is a contract between you and your insurance provider, NOT between providers and the insurance provider. Subsequently we cannot guarantee any insurance benefits. Patients are ultimately responsible for all charges incurred, regardless of insurance coverage.
For your convenience, we accept the following payment methods: CASH; VISA & MASTERCARD; PERSONAL CHECK. Any returned checks or denied cards will incur a fee of $45.00
All fees will be quoted to you before any treatment has begun. If you do not understand the fee quotes, or you have any questions, please do not hesitate to ask.

I ____ authorize Denture Services Northwest, Inc.
Patient/Guardian Name
for services/treatments and agree to pay any fees or charges for all services/treatments.

CANCELLATION POLICY OF DENTURE SERVICES NORTHWEST, INC.

I __________________________________ hereby acknowledge that I will be charged a $30.00
Patient / Guardian Name
fee for any broken appointments. If I am more than **15 minutes late**, my appointment will be considered a "NO SHOW" and I will be charged. I understand that I must inform the office if I cannot make my appointment or if I need to reschedule at least **24 hours** in advance. I also understand that this fee is NOT covered by insurance and will be billed directly to me.

My signature below indicates that I have been provided, have read and have a clear understanding of both the Financial and Cancellation Policies of Denture Services Northwest, Inc.

____

Signature **Date**

A copy of this signed policy will gladly be given to you upon request.