Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender: _____ Family Status: _____

Social Security #: _____ Birth Date: _____

Phone: (Mobile) _____ (Work): _____ Ext: ___ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Email Address: _____

Emergency Contact Name: _____ Phone _____ Relation _____

Health Information

Have you ever had any of the following? Please check those that apply and circle

- ☐ AIDS/HIV
- ☐ Arthritis
- ☐ Artificial Joints_____
- ☐ Premed/Dental Appts
- ☐ Asthma
- ☐ Auto immune_____
- ☐ Blood Disorder
- ☐ Cancer(type)_____
- ☐ Chemo(yr)_____
- ☐ Radiation(yr)_____
- ☐ Diabetes: Type I II
- ☐ Dizziness/Fainting
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Attack (Date)_____
- ☐ Hepatitis_____
- ☐ Blood Pressure High/Low
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental/Nervous Disorders
- ☐ Pacemaker
- ☐ Respiratory Problems
- ☐ Sinus Problems
- ☐ Sleep Apnea/Snoring
- ☐ Stroke (Date)_____
- ☐ Tuberculosis
- ☐ Tobacco/Marijuana/E-cig
- ☐ High Cholesterol
- ☐ Thyroid Condition
- ☐ Pregnant/Nursing
  Due Date_____

MEDICATION ALLERGIES:

_____
_____
_____
_____
_____
_____
☐ None

List of Current Medications

- Name of Physician: _____ Phone: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend / relative
Name: «RefBy_Title» «RefBy_FName» «RefBy_MI» «RefBy_Name»_____
☐ Dental Office ☐ Work ☐ Google ☐ Social Media ☐ Other _____

Responsible Party Information (If different than patient)

Name: _____

☐ Male ☐ Female ☐ Relationship to patient: _____

Social Security #: _____ Birth Date: _____

Phone: _____ (Work): _____ Ext: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code Phone

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address: _____

_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

Smile Source Spokane

Spokane, Washington

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Smile Source Spokane Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibili-ties and duties of this office with respect to my protected health information. The Statement of Privacy Prac-tices is also posted in the facility.

Smile Source Spokane Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a re-vised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
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 the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Smile Source Spokane
Financial Policy

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Smile Source Spokane and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility, and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that if I do not provide notice of cancellation at least 48 hours prior to my scheduled appointment time, a $50 fee may be applied to my account. We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. These appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

Date: _____ Signature: _____