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 DOB:____________________________

Social Security Number ________-_____-________ Driver's License #__________________________________

Mailing address____ City______________________________

State______ Zip code _______________ Email address ____

Cellphone__________________________ 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

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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

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

*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

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

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_____________________________________
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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: ____________________
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Medication: ______________________ Dosage: ________ Reason: ____________________

Please list any over-the-counter medicines or natural remedies you are currently taking: ____________
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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
Phentermine: 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 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
- Patients that pay in full on the date of service and complete their own dental billing (if they have dental insurance) receive 15% discount on dental and hygiene treatment at our customary fees with exception to cosmetic treatment
- 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
- 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 $75 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 mu Protected Healthcare Information to the person(s) identified below. I understand that the default answer is "NO" without indicting '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):

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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:

____

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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: ______________________________________