

# ADVANCED METROPOLITAN DENTISTRY

1220 Howell Street Ste. 160, Seattle, WA 98101 (206) 464-9002

|  |            |   |
|--|------------|---|
| PATIENT NAME (Last, First, Middle Initial)   |            | DATE OF BIRTH   |
| ADDRESS  |            | SS #  |
| CITY, STATE, ZIP   |            | MARITAL STATUS<br><input type="checkbox"/> Single <input type="checkbox"/> Married                                      |
| HOME PHONE   | CELL PHONE | SEX<br><input type="checkbox"/> Male <input type="checkbox"/> Female  |
| PREFER <input type="checkbox"/> Morning Appointment <input type="checkbox"/> Afternoon Appointment<br><input type="checkbox"/> No preference |            | RELATIONSHIP TO INSURED<br><input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child |
| EMPLOYER   |            | WORK PHONE  |
| OCCUPATION   |            | E-MAIL  |

## OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE

|      |               |      |
|------|---------------|------|
| NAME | DATE OF BIRTH | SS # |
| NAME | DATE OF BIRTH | SS # |

## WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

|         |              |
|---------|--------------|
| NAME    | PHONE        |
| ADDRESS | RELATIONSHIP |

## INSURANCE INFORMATION

### PRIMARY COVERAGE

### SECONDARY COVERAGE

|                           |                           |      |
|---------------------------|---------------------------|------|
| SUBSCRIBER'S NAME         | SUBSCRIBER'S NAME         |      |
| DATE OF BIRTH             | DATE OF BIRTH             |      |
| INSURANCE COMPANY         | INSURANCE COMPANY         |      |
| SOCIAL SECURITY/ID NUMBER | SOCIAL SECURITY/ID NUMBER |      |
| GROUP NUMBER              | GROUP NUMBER              |      |
|                           |                           |      |
| EMPLOYER                  | EMPLOYER                  |      |
| OCCUPATION                | OCCUPATION                |      |
| UPDATED ON                | SIGNATURE                 | DATE |

DO WE HAVE YOUR PERMISSION TO:

LEAVE A REMINDER REGARDING YOUR APPOINTMENT ON YOUR ANSWERING MACHINE, E-MAIL ADDRESS OR TEXT MESSAGE? Y N

SPEAK WITH OTHER MEMBERS OF YOUR HOUSEHOLD REGARDING YOUR APPOINTMENT OR DENTAL TREATMENT? Y N

IF YES, WHOM: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? Y N

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## Financial Arrangements and Office Policy

### **For all patients:**

To keep our fees as low as possible, we have eliminated billing. In order to secure an appointment time with Dr. Martini, *your co-payment is due at the time of scheduling*. If you are not prepared to pay your portion, your appointment will be rescheduled. If you do not have dental coverage, and need financial arrangements, we will make every effort to make your dental treatment affordable. For your convenience we accept Cash, Personal Checks, Visa, Master Card, Discover Card, American Express and Care Credit.

Initials \_\_\_\_\_

### **If you have dental coverage:**

As a service to you, we will file your treatment with your insurance company. We will estimate your deductible and the portion not covered by your insurance company, however, we cannot be held responsible for the accuracy of the insurance information, nor do we base our recommended treatment on your insurance coverage. You hereby authorize any insurance benefits to be paid directly to the Dentist. You will be responsible for all services not covered by your insurance company.

Initials \_\_\_\_\_

### **Billing Agreement from Patient:**

After my dental company has paid its portion of the dental services rendered to me at Advanced Metropolitan Dentistry, I hereby give my consent to that office to charge any outstanding balance to my credit card. This balance may include deductibles and denials as well as non-covered services.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Credit Card #: \_\_\_\_\_ Exp. Date: \_\_\_/\_\_\_/\_\_\_

Check One:  Visa  Master Card  American Express  Discover

### **Office Policy:**

If the need to cancel a scheduled appointment arises, we request a 48 hour notice. We understand that unforeseen circumstances can arise, however, appointments cancelled without prior notice or a "No Show" will result in a non-refundable fee of \$ **50.00 per ½ hour** of the scheduled appointment time. This will need to be paid before further appointments can be scheduled. Three consecutive cancellations or "No Show" appointments will result in dismissal from the practice.

Initials \_\_\_\_\_

If you are an adult patient with a scheduled appointment, and have a child, please arrange for care of your child offsite. Staff members are not responsible for caring for your child during treatment and we cannot be held liable for an unsupervised child. Children are not allowed in the treatment area or on the patient's lap during treatment. This can be dangerous to the patient and distracting to the dentist. **ONLY PATIENTS WILL BE PERMITTED IN THE TREATMENT AREA.** A tranquil environment will allow us to provide the best treatment possible. Anyone under the age of 18 must have an adult or guardian present in the office for the entire appointment time. Changes in treatment may occur, or unforeseen complications could arise, the dentist will not render treatment if the parent or guardian is not present and the appointment will be rescheduled.

Initials \_\_\_\_\_

No food or beverages are allowed in treatment area. Please be courteous to others and **turn off cellular phones**, as it disrupts our tranquil environment.

Initials \_\_\_\_\_

Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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## Notice of Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

Obtaining payment from third party payers (my insurance company).

The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are often bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires that we do so. You may see your record or get more information about it by contacting our privacy officer.

Print Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

## Consent for Release of Confidential Information

I authorize the dentist to perform diagnostic procedures and treatment as necessary for the delivery of proper dental care.

I authorize release of any information concerning my (or my child's) health care, for advice and treatment provided for the purpose of evaluation and administration of claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, for advice and treatment to another dentist, or another health care professional and their staff.

Print Patient Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

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Name: \_\_\_\_\_ Birthdate: \_\_\_/\_\_\_/\_\_\_ Sex: Male / Female

Physician Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Date of last health care exam: \_\_\_/\_\_\_/\_\_\_ What was the exam for? \_\_\_\_\_

Have you been hospitalized in the last 5 years? (Please circle) No Yes

If yes, reason:

\_\_\_\_\_

Are you currently receiving care? No Yes If yes, nature of care:

\_\_\_\_\_

Are you taking blood thinners such as aspirin or coumadin?

\_\_\_\_\_

Are currently taking any medications, prescription or over the counter drugs? No Yes

If yes, please list: \_\_\_\_\_

\_\_\_\_\_

Are you required to Pre-medicate before dental treatment? No Yes

Are you a smoker? If so, how much do you smoke per day? \_\_\_\_\_

Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? \_\_\_\_\_

Do you take Antacids? No Yes If yes, how often? \_\_\_\_\_

Are you taking any herbal supplements/medicines? No Yes If yes, which ones? \_\_\_\_\_

\_\_\_\_\_

Have you ever experienced abnormal bleeding? No Yes If yes, please explain \_\_\_\_\_

\_\_\_\_\_

Women: Are you pregnant? No Yes

If no, are you planning a pregnancy in the near future? No Yes

Are you nursing? No Yes

Are you taking birth control pills? No Yes

If yes, please list \_\_\_\_\_

## Are you allergic or have you reacted adversely to the following?

(please circle)

|              |              |         |                  |         |            |
|--------------|--------------|---------|------------------|---------|------------|
| Aspirin      | Codeine      | Demerol | Valium           | Sulfa   | Penicillin |
| Erythromycin | Tetracycline | Latex   | Local Anesthetic | Vicodin | Triazolam  |

Are you aware of being allergic to any other medications or substances? If yes, please list \_\_\_\_\_

Please circle yes or no any of the following which you have now or have had in the past . Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

|                             |    |     |                                |    |     |
|-----------------------------|----|-----|--------------------------------|----|-----|
| Angina Pectoris(chest pain) | NO | YES | Cosmetic Surgery               | NO | YES |
| Heart Disease/Attack/Stroke | NO | YES | Emphysema                      | NO | YES |
| Heart Failure               | NO | YES | Asthma                         | NO | YES |
| High/Low Blood Pressure     | NO | YES | Tuberculosis                   | NO | YES |
| Congenital Heart Defect     | NO | YES | Arthritis /Rheumatism          | NO | YES |
| Heart Murmur                | NO | YES | Venereal Disease               | NO | YES |
| Rheumatic Fever             | NO | YES | Frequent Headaches             | NO | YES |
| Heart Surgery               | NO | YES | Artificial Joints              | NO | YES |
| Heart Pacemaker             | NO | YES | Fever Blisters/Cold Sores      | NO | YES |
| Artificial Heart Valve      | NO | YES | Fainting                       | NO | YES |
| Diabetes                    | NO | YES | Seizures                       | NO | YES |
| Blood Transfusion/Anemia    | NO | YES | Hay Fever                      | NO | YES |
| Sickle Cell Disease         | NO | YES | Shingles                       | NO | YES |
| Bruise Easily               | NO | YES | Anxiety Disorder               | NO | YES |
| Hemophilia                  | NO | YES | Psychiatric Treatment          | NO | YES |
| Liver Disease (Jaundice)    | NO | YES | Chemical Dependency            | NO | YES |
| Hepatitis: A B C            | NO | YES | Glaucoma                       | NO | YES |
| Kidney Disease              | NO | YES | Cancer                         | NO | YES |
| Thyroid Disease             | NO | YES | HIV infection/AIDS             | NO | YES |
| Stomach ulcers              | NO | YES | HIV Positive/AIDS Related Com. | NO | YES |
| Lupus                       | NO | YES |                                |    |     |

Diet: Restricted diet: \_\_\_\_\_  
 How many meals a day: \_\_\_\_\_  
 Food allergies: \_\_\_\_\_  
 Sugar in your diet: (Please circle one) None Slight Moderate High

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the doctor of any changes in my health or medications.

Patient's Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Dr.'s Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

#### DOCTOR'S USE ONLY

Blood Pressure: Systolic      Diastolic      Pulse: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
    Systolic      Diastolic      Pulse: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_  
    Systolic      Diastolic      Pulse: \_\_\_\_\_ Time: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_

Comments on patient interview concerning medical history: \_\_\_\_\_  
 \_\_\_\_\_

Significant findings from questionnaire or oral interview: \_\_\_\_\_  
 \_\_\_\_\_

Dental Management considerations: \_\_\_\_\_