PATIENT'S HISTORY AND INFORMATION

(CONFIDENTIAL INFORMATION FOR OUR FILES)

(Please Print Clearly) Soc. Sec. No. _____ Date _____

Name _____ M F Birth date _____

Res. Address _____ City _____ Zip _____ Res. Phone _____

Email _____

Bus. Address _____ City _____ Zip _____ Bus. Phone _____

Employed by _____ Occupation _____ Spouse's Name _____

Referred by _____ Spouse's SSN _____

Spouse's Bus. Address _____ Bus. Phone _____

Employed by _____ Occupation _____ Spouse Date of Birth _____

Person Financially Responsible _____ Relationship _____

Res. Address _____ Res. Phone _____

Name of Group Dental Plan _____ Group No. _____

Emergency contact _____ Phone No. _____

DENTAL HEALTH HISTORY

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow healing sores in or about your mouth?	☐	☐
Are your teeth sensitive	☐	☐
Do you feel twinges of pain when your teeth come in contact with		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? _____		
How often do you floss? _____		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activity?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular jaw disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a bow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

Medical History

Patient Name: _____ Date of Birth: _____
Name and Address of Physician: _____
Date of Last Physical Exam: _____
Date of last Dental Exam & X-Ray: _____

Medications

During the past 12 months, have you taken any of the following:

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortizone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

Any other medications you are currently taking:

Medication	Condition

Current Conditions

Please check any of the following conditions you currently have or have had at any time in the past. Please also include the date of diagnosis if known. **Please check non of the above if none apply.**

Heart Trouble _____
Rheumatic Fever _____
Mitral Valve Prolapse _____
Angina Pectoris _____
Anemia _____
Glaucoma _____
Kidney Disease _____
Liver Disease _____
Epilepsy or Seizures _____
Cancer of Tumor _____
Chemotherapy _____
Radiation Therapy _____
IV Chemotherapy _____
Joint Replacement _____
Psychiatric Treatment _____
Stroke _____
Thyroid Problems _____
Developmentally Disabled ___
Hepatitis A, B, or C _____

High Blood Pressure _____
Heart Murmur _____
Pacemaker _____
Artificial Heart Valve
Heart Surgery
HIV
AIDS
Arthritis
Asthma
Diabetes
Sinus Trouble
Tuberculosis
Ulcers
Fainting or Dizzy Spells
Bruise Easily
Sickle Cell Disease
Blood Transfusion
Hemophilia
Cold Sores

Any other condition not mentioned above:
_____

None of the above _____

Do you have dentures? ☐ Yes ☐ No
If so, how old are they? _____
Do you have partials or flippers? ☐ Yes ☐ No
If so, how old are they? _____

History

	Yes	No
1. Are you allergic to any medications of drugs:? If so please list: _____	___	___
2. Have you had any unusual reaction to "Novocaine" or any other local anesthetic?	___	___
3. Have you ever had problems with prolonged bleeding from a cut, injury or tooth extraction?	___	___
4. Have you ever used, or are you currently using any narcotic drugs?	___	___
5. Are you in a substance recovery program?	___	___
6. Do you smoke? If so, how much? _____	___	___
7. Do you drink alcoholic beverages on a regular basis? If so, how much? _____	___	___
8. Do you have an allergy or other reaction to any metal?	___	___
9. Do you have any disease, condition or problem not previously listed? If so, please explain _____ _____	___	___

Women Only

	Yes	No
Are you taking birth control medications or any other hormone?	___	___
Are you pregnant, nursing, or possibly pregnant?	___	___

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient signature _____ **Date** _____
Provider signature _____ **Date** _____
Comments: _____
_____

Provider Initial _____ Date _____
Comment: _____
_____

Provider Initial _____ Date _____
Comment: _____
_____

Provider Initial _____ Date _____
Comment: _____
_____

Northwest Dental Services & Implant Center
725 St Helens Avenue S.
Tacoma, Washington 98402
253-383-3001

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I hae received a copy of the Statement of Privacy Practices for the offices of Northwest Dental Services & Implant Center. The Statement of Privacy Practive 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 responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Northwest Dental Services & Implant Center reserves the right to change the privacy practices that are 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 revised Statement of Privacy Practice by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		**YES**		**NO**
SPOUSE ONLY		**YES**		**NO**
OTHER *(PLEASE SPECIFY):*		**YES**		**NO**

Name of Patient or Personal Representative

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained					
PROVIDED PRIOR TO TREATMENT?		**YES**		**NO**	
DATE PROVIDED:					
REASON FOR DENIAL:		NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACE PRACTICES.			
		WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.			
		UNABLE TO SIGN.			
		REASON NOT GIVEN.			
		OTHER (EXPLAIN):			

Northwest Dental Service
725 St. Helens Avenue, Tacoma, WA 98402
(253) 383-3001

NORTHWEST DENTAL CENTER OFFICE POLICIES

WE ASK THAT ALL PATIENTS PLEASE READ AND BECOME FAMILIAR WITH THESE OFFICE POLICIES. WE APPRECIATE YOUR COOPERATION AS IT MAKES OUR JOB OF SERVING YOU MUCH EASIER.

1. PATIENTS WITH APPLE HEALTH CARE INSURANCE ARE RESPONSIBLE FOR MAINTAINING ACTIVE COVERAGE AT EACH APPOINTMENT TREATMENT IS PROVIDED, ANY SERVICES RENDERED WITHOUT COVERAGE IS THE PATIENT S RESPONSIBILITY.

2. WE ONLY ALLOW TWO NO SHOWS OR BROKEN APPOINTMENTS. WE WILL TRY TO CONFIRM YOUR APPOINTMENTS ONE DAY IN ADVANCE. IF WE ARE UNABLE TO REACH YOU DUE TO PHONE NUMBERS DISCONNECTIONS, ETC. IT IS YOUR RESPONSIBILITY TO CALL AND CONFIRM YOUR APPOINTMENT.

3. IF YOU NEED TO CANCEL OR RESCHEDULE YOUR APPOINTMENT, WE REQUIRE ONE DAY NOTICE. IF YOU DO NOT CONTACT US 24-HOUS PRIOR TO YOUR APPOINTMENT, THIS IS CONSIDERED A NO SHOW APPOINTMENT.

4. CHILDREN UNDER 8 YEARS OF AGE MUST HAVE ADULT SUPERVISION IN OUR WAITING ROOM AT ALL TIMES. ANY PATIENTS WITH CHILDREN NOT BEING SEEN ARE ASKED TO SEEK CHILD CARE FOR THEM WHILE BEING SEEN IN OUR OFFICE.

5. IF YOU ARE MORE THAN 15-MINUTES LATE FOR YOUR SCHEDULED DENTAL APPOINTMENT, YOU MAY BE ASKED TO BE RESCHEDULED.

6. PLEASE LET US KNOW IF THERE ARE ANY HEALTH, ADDRESS, OR PHONE NUMBER CHANGES SINCE YOUR LAST VISIT WITH US.

7. DUE TO THE LOW COST AND HIGH QUALITY OF DENTISTRY IN THIS OFFICE WE WILL REQUIRE FULL PAYMENT FOR DENTAL SERVICES ON THE DAY THEY ARE RENDERED. WE DO HOWEVER, ACCEPT MOST DENTAL INSURANCE PROGRAMS AND WILL BILL YOUR INSURANCE COMPANY OUR USUAL AND CUSTOMARY FEES. ANY AMOUNT NOT COVERED BY YOUR INSURANCE PLAN BECOMES THE PATIENTS RESPONSIBILITY. DELINQUENT ACCOUNTS ARE HANDLED BY AN OUTSIDE COLLECTOR AND ANY ADDITIONAL FEES CHARGED BY THE COLLECTOR ALSO BECOME THE RESPONSIBILITY OF THE PATIENT.

8. I UNDERSTAND THAT PAYMENT IS DUE AT THE CONCLUSION OF EACH APPOINTMENT AND I ACCEPT FINANCIAL RESPONSIBILITY FOR CHARGES MY/MY CHILD'S TREATMENT. I HEREBY AUTHORIZE ANY PAYMENT OF PROFESSIONAL SERVICES CHARGED TO MY INSURANCE TO BE PAID DIRECTLY TO NORTHWEST DENTAL.

9. I, BEING THE PARENT OR LEGAL GUARDIAN OF THE CHILD NAMED ON THIS FORM, DO HEREBY AUTHORIZE AND REQUEST THE PERFORMANCE OF DENTAL SERVICES UPON THIS PATIENT. I ALSO AUTHORIZE EMERGENCY PROCEDURES THAT, IN THE JUDGMENT OF THE DOCTOR, MAY BE NECESSARY DURING TREATMENT.

SIGN _____ DATE _____
(PARENT OF GUARDIAN)

THANK YOU FOR YOUR COOPERATION

WE LOOK FORWARD TO SERVING YOUR DENTAL NEEDS

SIGN _____ DATE _____