West Valley Dental

Welcome to our office. To assist us in serving you please complete the following form. The information provided on this form is important to your dental health. Information is completely confidential.

A. PERSONAL INFORMATION (If patient is a minor, form must be completed by parent)

Today's Date_____ *Is another family member a patient at this office? Y N*

Patient Name_____ Male_____Female_____

Home Address_____Birthdate_____

City / State_____Zip Code_____SSN_____

Home Phone_____Cell Phone_____Work Phone_____

E-Mail Address (to confirm appointments)_____

Employer_____Occupation_____

If patient is a minor: **Name of Parent**_____

Person financially responsible for account_____

EMERGENCY CONTACT: Name and Phone Number_____

Relationship_____**Phone**_____

B. DENTAL INSURANCE INFORMATION

Subscriber's Name_____**Primary Insurance Company**_____

Group/Policy #_____Birthdate_____SSN_____

Are you covered by a 2nd plan? Y N Insurance Co._____Group/Policy #_____

Subscriber's Name_____Birthdate_____SSN_____

CONSENT: I authorize the staff of West Valley Dental to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by West Valley Dental to make a thorough diagnosis of the patient's dental needs. I also authorize West Valley Dental to perform any and all forms of treatment, medication, therapy, that may be indicated and further authorize and consent that West Valley Dental choose and employ such assistance as they deem fit. I also understand the use of anesthetic agents embodies a certain risk.

CONSENT FOR ELECTRONIC COMMUNICATION: Our office utilized the convenience of email and text messaging. By using our practice's electronic services, you agree that our office may send to you any of the following that you identify as a communication that can be sent through the internet to the address designated above. All electronic communications from our practice to you will be sent from our secured, non-encrypted email server. Unencrypted email is not a secure form of communication there is some risk that any individually identifiable health information and other sensitive or confidential information that may be contained in such email may be misdirected, disclosed to intercepted by, unauthorized third parties. However, you may consent to receive email from us regarding your treatment. We will use the minimum necessary amount of protected health information in any communication. ***West Valley Dental does not share or sell the names, email addresses, and/or telephone numbers of patients with any other company, or with any other patient.***

☐ **I consent and accept the risk of receiving information via email and text.**
☐ **I consent only to receiving appointment reminders via email or text.**
☐ **I do not consent to receiving any information via email or text.**

I understand that I can change my mind and provide consent later or withdraw my consent at any time.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the above information is true and correct. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist or his staff of any changes at any subsequent appointment.

Print Name:_____

Signature:_____ **Date:**_____

Parent or Guardian:_____ **Date:**_____

West Valley Dental

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DENTAL HEALTH HISTORY

	YES	NO
1. Do you want to learn to control dental disease and retain your teeth?	_____	_____
2. Would you like to change the color or appearance of your teeth?	_____	_____
3. Do your gums bleed when brushing?	_____	_____
4. Have you ever had an ongoing problem with bad breath?	_____	_____
5. Are your teeth sensitive?	_____	_____
6. Do you smoke or chew tobacco?	_____	
7. Do you drink alcohol? If so, how much?_____	_____	_____
8. Have you had any teeth removed? If so, when?_____	_____	_____
9. Do you gag easily?	_____	_____
10. History of head injury? If so, when?_____	_____	
11. How often do you brush?_____		
12. How often do you floss?_____		

13. Have you ever had an adverse reaction to local anesthetic?_____

14. Have you had problems with previous dental treatment?_____

15. Why did you leave your last dentist?_____

MEDICAL HEALTH HISTORY

16. Are you aware of being **allergic** to or have you ever reacted adversely to any of the following? **Y N (please circle)**

a. Penicillin or other antibiotics
b. Aspirin, Acetaminophen or Ibuprofen
c. Codeine or other narcotics
d. Sulfa drugs
e. Latex or rubber dam
f. Reaction to costume jewelry or metals
g. Sedatives or sleeping pills
h. other (please specify)_____

17. Do you have, or have you had any of the following? (Please mark YES or NO for each)

Heart Problems		
Chest pain	Y	N
Shortness of breath	Y	N
Blood pressure problems	Y	N
Heart murmur	Y	N
Heart valve problem	Y	N
Taking heart medication	Y	N
Rheumatic fever	Y	N
Pacemaker	Y	N
Artificial heart valve	Y	N
Blood Problems		
Easy bruising	Y	N
Frequent nosebleeds	Y	N
Abnormal bleeding	Y	N
Blood disease (anemia)	Y	N
Ever require a blood transfusion	Y	N
Allergy Problems		
Sinus Problems	Y	N
Skin rashes	Y	N
Asthma	Y	N
Intestinal Problems		
Ulcers	Y	N
Kidney or bladder problems	Y	N
Bone or Joint Problems		
Arthritis	Y	N
Joint replacement	Y	N
Sleep Apnea		
Do you snore	Y	N
Quit breathing while sleeping	Y	N
Tired or fatigued	Y	N
Fall asleep while driving	Y	N
Other		
Diabetes	Y	N
Hepatitis, jaundice or liver trouble	Y	N
Herpes or other STD	Y	N
HIV-positive / AIDS	Y	N
Glaucoma	Y	N
Epilepsy or other neurological disease	Y	N
History of alcohol or drug abuse	Y	N
Thirsty or mouth is dry	Y	N
Fainting spells, seizures or epilepsy	Y	N
Frequent or severe headaches	Y	N
Thyroid problems	Y	N
Tuberculosis / Respiratory disease	Y	N
Cancer / tumor	Y	N

If you answered yes to any of the above, please provide a short description:

_____

Do you have any disease, condition or problem not listed above that you feel we should know about?_____

_____

Do you require premedication for dental treatment? (Would be required by physician): Y N If yes, for what?_____

Are you currently taking any medications, drugs, pills, or alternative (herbal) medicines? **Y N** If yes, please list:

_____

Are you currently being treated by a physician? If so, for what? Please provide physician's name & phone number:

_____

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

Antibiotics or sulfa drugs	Y	N
Anticoagulants (e.g. Coumadin)	Y	N
High blood pressure medication	Y	N
Tranquilizers	Y	N
Insulin, Orinase, or similar drug	Y	N
Aspirin	Y	N
Digitalis or drugs for heart trouble	Y	N
Cortisone (steroids)	Y	N
Natural remedies	Y	N

Other_____

WOMEN ONLY: *a. Are you taking oral contraceptives or other hormones? Y N*

b. Are you pregnant?_____ If yes, what month?____

c. Name and phone number of OB/GYN:_____

If you are pregnant, then you must provide prior to your first treatment appointment, a note from your physician authorizing x-rays, medications and/or dental treatment. Please mention to our receptionist.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the above information is true and correct. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist or his staff of any changes at any subsequent appointment.

Print Name:_____

Signature:_____ Date:_____

Parent or guardian:_____ Date:_____

West Valley Dental
15668 West Valley Hwy • Tukwila, WA 98188 • (425) 430-9099

OUR CANCELLATION & RESERVATION POLICY

Because of the overwhelming demand for dental appointments from our clients, we have found it necessary to adopt the following policy regarding appointments. This is intended to assure that valuable appointments are used as effectively as possible.

Your appointment time is especially reserved for you. If you must cancel an appointment, please notify us as soon as you know you will not be able to keep your scheduled appointment. Any change in your appointment greatly affects our patients and staff. When a patient does not show, or cancels or reschedules his or her appointment within less than 48-hours, it deprives others of timely care, and wastes dentist and staff time. More importantly, your dental treatment is delayed, which in many cases further complicates the condition and adds to your expense.

Appointment Reservations:
, if not the entire day. If you are scheduled for a complicated procedure (ie oral surgery, endodontic, sedation, implants. etc) or where special parts need to be ordered specifically for your case, we require prepayment to reserve your appointment. We can provide you and itemized invoice for any prepaid expenses in advance so you will know exactly what is required as prepayment. All appointments of this nature will require a $1500 non-refundable deposit. This reservation fee must be paid when the appointment is made. The deposit will be applied toward the dental care you receive.

If you cannot keep your appointment, you are expected to contact our office during regular work hours with at least 2-business days' notice. Appointments cancelled without 2-business days notice and complete "no-show" appointments will forfeit all reservation deposits. If an appointment is cancelled with less than 2 business days' notice and you wish to reschedule, we will collect a non-refundable fee of $50 at the time of rebooking. Additionally, patients who repeatedly miss their appointments may be subject to dismissal from future care by this office.

Thank you, in advance, for your understanding and consideration.

I have read the Cancellation Policy and I understand and agree to abide by this Policy:

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best and most appropriate dental care to suit your individual needs. To facilitate quality care, we believe it is important that you be kept well informed. Good communication is essential to a healthy provider-patient relationship.

The following financial policy will assist you in handling your account with us. Please read this form carefully and sign below. We are happy to answer any questions, please do not hesitate to ask.

INSURANCE:

Acceptance of Insurance: As dental care providers we must emphasize that our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract except where we are preferred provider. Your plan benefits depend solely on what your employer wishes to offer you and your fellow employees. The extent of coverage has nothing to do with the level of service provided by our office and the fee charged for these services. **While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.**

For your convenience, we will call your insurance company to verify patient eligibility as well as obtain an estimate of insurance coverage. **However, insurance plans vary greatly in the types of coverage they offer and we expect you to become familiar with your policy's benefits and limitations.** Furthermore, as your insurance company will inform you when you call, "benefits quoted are not a guarantee of payment as they are subject to current plan provisions or eligibility." You will be held financially responsible for services, which are not covered by your insurance plan.

Based on information provided by your insurance company, we will provide an estimate that will show expected insurance payment and estimated patient payment for each procedure. However, the estimated insurance payment should be considered a guideline until the final insurance payment is received and posted to your account. Please note that our fees may not correspond with those of your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates (UCR). If you have questions regarding UCR, please ask. **Our office CANNOT GUARENTEE the insurance payment as estimated.**

You will receive a statement each month to keep you informed of the status of your account. Your billing statement will reflect recent activity on your account including payments received and payment due from you or your insurance company. You are responsible for any payment not made by you insurance company within 60 days. We cannot accept responsibility of collecting an overdue insurance claim or for negotiating a disputed claim. However, we will make every effort to assist you with any questions or concerns you may have regarding your account.

FEES & PAYMENTS:

We share your concerns about the cost of dental care. Our fees have been thoughtfully worked out to reflect fair charges for our time, expertise, materials and the complexity of your treatment.

We are a fee-for-service practice. We expect payment in full at the time of service. We accept cash, checks and major credit cards.

Financing/Payment Plans: For the convenience of our patients, we offer payments through various outside financing companies. Information about those programs are available upon request. Please ask to speak with our Patient Care Coordinator.

FINANCIAL ARRANGEMENTS:

To minimize any fee-related misunderstandings, we make financial arrangement before starting treatment. The treatment fee is based on information gained from an examination of the patient and review of patient information. Should additional problems arise as treatment progresses, this estimated fee might be revised. The patient will be informed of any increased fees and/or additional recommended treatment. Any treatment cost not covered by insurance will be due at the time of treatment unless prior arrangements have been made.

Returned Checks: There will be a $25.00 handling charge for any returned checks.

Finance Charge: The total balance of account is subject to a 1.5% per month (18% APR) service charge after 60 days. If any installments are not paid when due, the whole, unpaid balance may, at our option, become immediately due.

I have read the Financial Policy and I understand and agree to this Financial Policy:

_____ **Date:**_____

Signature of Patient or Responsible Party

_____

Print Name

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PHONE: (425) 430-9099

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 (HIPPA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up 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 above address 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. I also 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.

Patient Name:_____ Date:_____

Signature:_____ Date:_____

Relationship to Patient:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____