567 John Street Suite 2
Seattle, WA 98109
PHONE 206-724-0188 | FAX 206-724-0488 | WWW.LOVEYOURSMILE.DENSTIST

Patient Information

Name: _____ Preferred Name: _____

Home Address: _____ City: _____ State _____ Zip: _____

Home #: _____ Work #: _____ Mobile #: _____

Email: _____

Sex: M / F Birth Date: ___ /___ /_____ SS#:_____

Family Status (circle): Single Married Divorced Child Spouse's Name: _____

How did you first hear about our office? (circle one):

Another Patient	Another Dental Office	Brochure	Online Search
Facebook	Work	School	Insurance Website
Sign –Drive by	Walk in	Other:_____	

Whom may we thank for referring you to our practice?_____

Person Responsible for Account

Name of responsible party: _____

Relationship to patient (Circle): Self Spouse Parent Other: _____

Home Address: _____ City: _____ State: _____Zip: _____

Home #: _____Work #: _____ Mobile #: _____

Email: _____

Birth Date: ___ /___ /_____ SS#:_____

Contact Information

What is the best way to communicate with you? Home Phone / Mobile Phone/ Text / Email

In the event of an emergency, whom should we contact? Name _____

Relationship_____ Phone #: _____

Insurance Information (Primary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #: _____

Group #: _____ ID #: _____

Insurance Information (Secondary)

Name of Insured: _____ Relationship to patient: _____

Insured Birth Date: ___ /___ /_____

Insurance Plan Name: _____ Insurance Co Phone #:_____

Group #: _____ ID #: _____

Employment Information

Employer Name: _____ Phone: _____

Address: _____

City, State, Zip: _____

Medical History

Patient Name: _____ Date of Birth: _____

1. Date of last physical exam: _____ Physician's Name: _____
Physician's Phone#: _____
2. Have you ever been hospitalized (if yes, explain below)? Yes No
_____
3. Have you been under the care of a medical doctor during the past two years? Yes No
If yes, what for? _____
4. Have you ever had any excessive bleeding requiring special treatment? Yes No
5. Women: Are you pregnant/trying to get pregnant/breast feeding? Yes No

6. Are you allergic to or have you had an allergic reaction to any of the following (please circle if yes):

Local Anesthetic	Penicillin	Codeine	Other Antibiotic: _____
Latex	Acrylic	Metals	Other:_____

7. Are you taking or have you ever taken any of the following medications (please circle if yes):

Fosamax	Actonel	Boniva	For how long? _____
Aredia	Reclast	Zometa	When did you stop? _____

8. Please list other medications you are taking:
_____

Dental History

1. Date of last dental exam:_____ Date of last dental x-rays: _____
2. Previous dentist's name / location:_____
3. Are you having tooth or gum pain at this time? Yes No
4. Do you feel nervous about having dental treatment? Yes No
5. Have you ever had a bad experience in a dental office? Yes No
6. Do your gums bleed when brushing / flossing? Yes No
7. Have you ever seen a periodontist? Yes No
8. Have you ever had a "deep cleaning" (Scaling and Root Planing)? Yes No
9. Is there anything you would like to speak with the Doctor about in private? Yes No
10. Would you be interested in discussing ways to improve your smile? Yes No

If yes, please explain: _____

Do you have any of the following dental concerns:

Clicking in jaw joint	Yes No	Sensitivity to:	Hot	Cold	Sweets	Biting
Pain in or around your ears	Yes No	Swelling		Bleeding Gums		
Difficulty opening or closing	Yes No	Bad Taste		Bad Breath		
Difficulty chewing	Yes No	Food Catching		Tooth Pain		
History of trauma to jaw or face	Yes No	Clenching		Grinding		
Diagnosis of TMJ/TMD	Yes No	Other: _____				

Have you ever had any of the following?

Chest Pains	Yes No	Shortness of Breath	Yes No	Hives/Skin Rashes	Yes No
Heart Failure	Yes No	Ulcers	Yes No	Alcoholism	Yes No
Heart Disease	Yes No	Mental Health Issues	Yes No	Herpes	Yes No
Heart Attack	Yes No	Emphysema	Yes No	Glaucoma	Yes No
Heart Problems	Yes No	Fainting/Dizziness	Yes No	Steroid Treatment	Yes No
Angina Pectoris	Yes No	Eating Disorder	Yes No	Arthritis	Yes No
Heart Surgery	Yes No	Epilepsy/Seizures	Yes No	Dental Implant	Yes No
Liver Disease	Yes No	Persistent Cough	Yes No	Dentures/Partials	Yes No
Hypertension	Yes No	Tuberculosis	Yes No	Birth Defects	Yes No
Heart Murmur	Yes No	Asthma	Yes No	HIV+, AIDS, ARC	Yes No
Rheumatic Fever	Yes No	Hepatitis A	Yes No	Hay Fever	Yes No
Mental Disorder	Yes No	Hepatitis B	Yes No	Tobacco Products	Yes No
Hepatitis C or D	Yes No	Sickle Cell Disease	Yes No	Bruise Easily	Yes No
Sinus Trouble	Yes No	Pacemaker	Yes No	Jaundice	Yes No
Artificial Joints	Yes No	Night Sweats	Yes No	Kidney Trouble	Yes No
Thyroid Disease	Yes No	Stroke	Yes No	Diabetes	Yes No
Anemia	Yes No	Drug Addiction	Yes No	Chemotherapy	Yes No
Blood Transfusion	Yes No	Cold Sores	Yes No	Cancer	Yes No
Mitral Valve Prolapse (MVP)	Yes No	Radiation Therapy	Yes No	Transplant	Yes No

I understand the importance of a truthful health history and realize that incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information above is complete and accurate.

Signature:_____Date_____

Doctor's Signature_____

Doctor's Notes:

OFFICE POLICY

We appreciate you choosing our practice for your dental care. In order for us to provide you with optimal service, we would like you to take a moment to read our office guidelines.

Payment is expected on the day of service. Our office does not bill patients. We will accept payment by cash, check, or credit card (Visa, MasterCard or American Express). Any checks that are declined will result in a $50.00 fee. We do accept Care Credit.

If you have insurance, we will bill the insurance company as a courtesy to you, however you are responsible for all charges incurred after insurance payment or insurance non-payment. **We do collect your co-payment at the time of service and any estimated portion.** If your insurance company (primary or secondary) denies charges for any reason the financial responsibility is yours.

Minors (patients 18 years and younger) must be accompanied by a parent or legal guardian for ALL appointments. Unaccompanied minors will be denied treatment unless treatment and payment has been approved. Parents and legal guardians are not permitted in the operatories and are asked to wait in the reception area during treatment.

I understand that my appointment time has been reserved for me and that Love Your Smile confirms appointments as a courtesy to me. **In the event that I need to reschedule an appointment I understand Love Your Smile requires 48 hours (two days) notice. I understand if I am unable to give 48 hours notice I may be charged a fee of $75 for the last minute cancellation/reschedule. Any missed appointments will also incur a $75 fee.** I understand that if I am more than 15 minutes late for a scheduled appointment, I will not be able to be seen that day and will have to reschedule my appointment.

I authorize the dentist to perform diagnostic procedures and treatment for proper dental care. I authorize the release of any information concerning my (or my child's) dental health care and treatment provided for the purpose of evaluating and administering claims for insurance benefits.

I have read the office guidelines and understand and agree to these guidelines.

Patient/Guardian Signature _____ Date _____

STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Statement of Privacy Practices for the office of Love Your Smile. The Statement of Practices describes the type of uses of disclosures of my protected health information that might occur in my treatment, payment for service, or in the performance of health care operations. The Statement of Privacy Practices also describes my right and the responsibilities and duties of this office with respect to my protected health information.

Love Your Smile 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.

Patient Name: _____ Date _____

Signature: _____ Relationship to patient: _____

FOR OFFICE USE ONLY:
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reasons:

- Patient refused to sign
- Patient unable to sign
- Communication barriers
- Emergency situation
- Other _____