



## Patient Information

Mr.  Mrs.  Ms.  Dr. First Name \_\_\_\_\_ M.I. \_\_\_\_\_ Last Name \_\_\_\_\_  
 Sex:  Male  Female Birth Date: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Driver Lic # \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_ Home Tel: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Tel: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Nearest relative not living with you \_\_\_\_\_ Tel: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_ Tel: ( \_\_\_\_\_ ) \_\_\_\_\_



## Who Will be Responsible for Your Account?

Self (If self, skip this step)  Father  Mother  Other (Relation to you) \_\_\_\_\_  
 Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Email: \_\_\_\_\_ Home Tel: ( \_\_\_\_\_ ) \_\_\_\_\_ Cell: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Tel: ( \_\_\_\_\_ ) \_\_\_\_\_

### Spouse or other Guarantor Information (If different from above)

Name: \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Relation: \_\_\_\_\_ Email: \_\_\_\_\_ Home Tel: ( \_\_\_\_\_ ) \_\_\_\_\_  
 Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_



## Primary Insurance

**Insurance Type:**  Dental  Medical

Insured Party: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Sex:  Male  Female Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Tel: ( \_\_\_\_\_ ) \_\_\_\_\_ SS# \_\_\_\_\_  
 ID # \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Bus. Address: \_\_\_\_\_  
 Bus. Tel: ( \_\_\_\_\_ ) \_\_\_\_\_ Plan: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**Insurance Co. Name:** \_\_\_\_\_  
 Address: \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Group Name:** \_\_\_\_\_



## Secondary Insurance

**Insurance Type:**  Dental  Medical

Insured Party: \_\_\_\_\_ Relation: \_\_\_\_\_  
 Sex:  Male  Female Birth Date: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Tel: ( \_\_\_\_\_ ) \_\_\_\_\_ SS# \_\_\_\_\_  
 ID # \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Bus. Address: \_\_\_\_\_  
 Bus. Tel: ( \_\_\_\_\_ ) \_\_\_\_\_ Plan: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
**Insurance Co. Name:** \_\_\_\_\_  
 Address: \_\_\_\_\_  
**Group #** \_\_\_\_\_ **Group Name:** \_\_\_\_\_

## Consent for Treatment

1. I hereby authorize Dr Winans, Dr. Hunter, Dr. Craig or their designated staff to take x-rays, study models, photographs, and other diagnostics as deemed appropriate for diagnosis of my dental needs. 2. Upon diagnosis, I authorize Dr. Winans, Dr. Hunter, Dr. Craig or their designated staff to perform any recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. 3. I agree to the use of anesthetics, sedatives, and other medications where necessary. I fully understand that use of anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

X \_\_\_\_\_  
 Signature of Patient (Parent or Guardian if Minor)

X \_\_\_\_\_  
 Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X \_\_\_\_\_  
 Signature of Patient (Parent or Guardian if Minor)

X \_\_\_\_\_  
 Date



# Medical History



TENINO  
FAMILY  
DENTAL  
CENTER

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  Male  Female

Physician's Name \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

Preferred Pharmacy \_\_\_\_\_ Location \_\_\_\_\_ Phone \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Are you under a physician's care?  Yes  No



## Do You or Have You Had the Following

### Heart

- Yes  No Chest Pain
- Yes  No High/Low Blood Pressure
- Yes  No Pace Maker
- Yes  No Heart Murmur, Fibrillation, Congenital Defects
- Yes  No Artificial Heart Valve, Date \_\_\_\_\_

### Infections

- Yes  No Swollen Glands
- Yes  No HIV/AIDS, STD, Herpes
- Yes  No Hepatitis, Type \_\_\_\_\_
- Yes  No Rheumatic, Scarlet Fever

### Respiratory

- Yes  No Shortness of Breath
- Yes  No Snoring
- Yes  No Tuberculosis
- Yes  No Asthma, Inhaler  Yes  No
- Yes  No COPD/Emphysema

### Circulatory

- Yes  No Dizziness/Fainting
- Yes  No Circulatory Problems
- Yes  No Excessive bleeding
- Yes  No Stroke, Date \_\_\_\_\_

### Allergies

- Yes  No Metal
- Yes  No Latex
- Yes  No Antibiotics
- Yes  No Other \_\_\_\_\_

### Medications & Supplements

\_\_\_\_\_  
\_\_\_\_\_

### Head & Neck

- Yes  No Glaucoma
- Yes  No Jaw Pain/Headaches
- Yes  No Tumor or Growth on Head or Neck
- Yes  No H & N Radiation Treatment: Date \_\_\_\_\_
- Yes  No Sinus Problems

### Systemic

- Yes  No Stomach Problems
- Yes  No Arthritis/Rheumatism
- Yes  No Artificial Joint,  
Joint \_\_\_\_\_ Date \_\_\_\_\_ Pre-med \_\_\_\_\_
- Yes  No Cancer, Chemo,  
Radiation, Surgery Type, Date \_\_\_\_\_
- Yes  No Diabetes:  Type 1  Type 2
- Yes  No Epilepsy/Seizure
- Yes  No Kidney, Liver Disease
- Yes  No Nervous System Condition
- Yes  No Thyroid Problems

### Other

- Yes  No Bisphosphonates/Bone Density Meds
- Yes  No Surgeries? Date \_\_\_\_\_
- Yes  No Pregnant, Due Date \_\_\_\_\_
- Yes  No Vertigo
- Yes  No Chronic Pain
- Yes  No Chemical Dependency
- Yes  No Mental Health Care
- Yes  No Smoking,  
How much? \_\_\_\_\_ How Long? \_\_\_\_\_
- Yes  No Alcohol,  
How much? \_\_\_\_\_ How Long? \_\_\_\_\_
- Yes  No Complications w/ Previous Dental Treatment

### Notes

\_\_\_\_\_  
\_\_\_\_\_

I certify that the above information is complete and accurate to the best of my knowledge.

X \_\_\_\_\_  
Signature of Patient (Parent or Guardian if Minor)

X \_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Date

# Financial Policy

It is our policy to receive payment in full for dental treatment at the time of service. We realize that each person's financial situation is different. For this reason we provide the following options to help you receive the dental care needed to enjoy a healthy and confident smile.

## Dental Insurance

We are happy to file the necessary forms to see that you receive the full benefits of your coverage; however, we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we consider all patients responsible directly for all charges. Your estimated portion is due at the time of service. We can take no responsibility for plan benefit maximums, denied coverage or required co-payments. If for some reason your insurance company has not paid their portion within 30 days from the date of service, you are responsible for the balance at that time. In addition, 1.5 % will automatically be added monthly on any remaining balance until paid in full.

## Uninsured

We request payment in full at the time of service, payable by cash, check, or major credit card. We also have applications on hand for a dental line of credit that offers interest-free options.

## Payment Options

- Cash or Check
- Credit Cards: We gladly accept payment by most credit cards
- Health Care Credit Card: Interest free options available on approval of credit

## Cancellation / Broken Appointment Policy

There will be a charge of \$50 per hour for appointments cancelled or broken without 48 hours notice.

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure or surgery you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge.

**It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney fees, and court costs.

I have read and understand the above financial policy. Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependents. I authorize Tenino Family Dental Center to furnish information to insurance carriers concerning my or my dependent's treatment. I hereby assign to the dentist all payments for dental services rendered.

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to this doctor named of the benefits otherwise payable to me.

X \_\_\_\_\_  
Signature of Patient (Parent or Guardian if Minor)

X \_\_\_\_\_  
Date