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 fo diagnosis of my den- tal needs. 2. Upon diagnosis, I authorize Dr. Winans, Dr. Hunter, Dr. Craig or their designated staff to perform any recommended treatment mutuall 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 neces sary. 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 _____ ***X*** _____

Signature of Patient (Parent or Guardian if Minor) 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 _____ ***X*** _____

Signature of Patient (Parent or Guardian if Minor) 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 _____

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

Medications & Supplements

_____

_____

Notes

_____

_____

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

x _____ *x* _____

Signature of Patient (Parent or Guardian if Minor) 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 once 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 _____ ***X*** _____

Signature of Patient (Parent or Guardian if Minor) Date