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

PATIENT INFORMATION

Patient's Name ______________________________ Preferred Name ______________________________

Birthdate ______________________________ SS# ______________________________

Marital Status ______________ Drivers License # ______________________ State ____________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

Mailing Address ______________________ City ______________ State _____ Zip ____________

Email ____

Employer ______________________________ Occupation ______________________________

Whom may we thank for referring you to our office? ______________________________

Is an immediate family member a patient here? ❑ no ❑ yes Name: ______________________________

May we contact you regarding upcoming appointments, reminders, or office specials via ❑ Email and/or ❑ Text Message

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INSURANCE INFORMATION: ❑ Not covered by dental insurance

Insured Name ______________________________ Insured Date of Birth ______________

Insured Employer ____

Insured ID or Social Security # _ ______________ Dental Insurance Co ______________________________

Group Number ______________________________ Phone Number ______________________________

RESPONSIBLE PARTY INFORMATION: ❑ Self ❑ Other

Name ______________________________ Relationship To Patient ______________

Birthdate __________ Social Security # ______________ Driver's License # ______________

Address ______________________ City ______________ Zip __________ State ________

Home Phone ______________ Work Phone ______________ Cell Phone ______________

EMERGENCY CONTACT INFORMATION:

Name of Emergency Contact ______________________ Relationnship to Patient ______________

Home Phone ______________________________ Cell Phone ______________________________

Address ______________________ City ______________ Zip __________ State ________

Patient's Signature: ______________________________________ Date: ______________

Parent/Guardian *(if patient is a minor)*: ______________________________________

BFD
BELLINGHAM
FAMILY DENTISTRY

MEDICAL HEALTH HISTORY

Do you have or have you had any of the following?
(Please check any that apply)

- ❑ AIDS/HIV Postive
- ❑ Allergies or Hives
- ❑ Anemia
- ❑ Angina Pectoris
- ❑ Arthritis
- ❑ Artifical Joint or Heart Valve
- ❑ Asthma
- ❑ Blood Tranfusion
- ❑ Bruise Easily
- ❑ Chemotherapy
- ❑ Cold Sores/Fever Blisters
- ❑ Congenital Heart Defects/Lesions
- ❑ Cortisone Medicine
- ❑ Cough
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy/Seizures
- ❑ Fainting/Dizzy Spells
- ❑ Glaucoma
- ❑ Heart Attack/Disease
- ❑ Heart Failure
- ❑ Heart Murmur
- ❑ Heart Surgery
- ❑ Hepatitis A or B
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Kidney Trouble
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Pace Maker/Defibrillator
- ❑ Psychiatric Treatment
- ❑ Radiation Treatment
- ❑ Rheumatism
- ❑ Sleep Apnea
- ❑ Sickle Cell Disease/Traits
- ❑ Stroke
- ❑ STD or VD
- ❑ Thyroid Disease
- ❑ Tuberculosis
- ❑ Ulcers/Colitis
- ❑ Other: ______________________________

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin
- ❑ Other:______________________________
- ❑ Other:______________________________

Are you taking any of the following?

- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

Please list **ALL** current medications/supplements/vitamins you are taking:

____

____

____

Do you smoke or use chewing tobacco? ❑ yes ❑ no

Name of your Physician:______________________________

Phone number ______________________________

Name: ______________________________

Phone Number: ______________________________

Women:

- ❑ May be pregnant
- ❑ Taking hormones or contraceptives

Have you been hospitalized or had a serious operation or illness within the last five years? ❑ yes ❑ no

Do you have any disease, condition, or problem not listed above?______________________________

CONSENT: *I ______________________________, authorize the Doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the Doctor to make a thorugh diagnosis of the patient's dental needs. I also authorize the Doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with the Patient and further authorize and consent that the Doctor choose and employ such assistance as he deems fit. I also understand the use of anesthetic agents embodies a certain risk.*

Patient's Signature: ______________________________ Date: ______________ Witness: ______________

Parent/Guardian *(if patient is a minor)*: ____ Relationship To Patient: ________________

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, filing insurance, and health care operations.

You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and health care operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice at any time

Bellingham Family Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF HIPAA NOTICE OF PRIVACY PRACTICES

("Acknowledgement")

I acknowledge that I have received a copy of this Dental Practice's **HIPAA Notice of Privacy Practices**.

Patient's Name: ________________________________Date: ____________________________

Please list person(s) we can release information to on your behalf:

____

____

Patient's Signature

-OR-

Signature of Personal Representative: ____

Authority of Personal Representative to Sign for Patient (check one):

❑ Parent ❑ Guardian ❑ Power of Attonery ❑ Other

PLEASE NOTE: IT IS YOUR RIGHT TO REFUSE TO SIGN THIS ACKNOWLEDGEMENT.

FOR DENTAL STAFF ONLY

I tried to obtain written Acknowledgement by the individual noted above of receipt of our **Notice of Privacy Practices**, but it could not be obtained because:

❑ An emergency prevented us from obtaining acknowledgement.
❑ A communication barrier prevented us from obtaining acknowledgement.
❑ The individual was unwilling to sign.
❑ Other:____

OFFICE POLICIES

Cancellation Policy

A reserved appointment time in any dental office is limited and valuable. It is extremely important that all patients honor their reserved dental appointments. Failure to do so deprives our other patients from receiving their dental care in a timely fashion.

We require that one week notice be provided for rescheduling or cancelling your appointment. Our policy stipulates that failure to give sufficient notice to keep a scheduled surgical appointment may result in your deposit becoming non-refundable.

Every effort is made to contact patients to confirm your appointment time and date. Our staff will contact you 1-2 days prior to your scheduled appointment to confirm with you. Please understand that this is a courtesy call, text, or email. **DO NOT DEPEND ON THIS**. If we are unable to reach you, your appointment card will serve as your confirmation of the appointment and implies your obligation to be present.

Financial Policy

In addition to presenting you with the best treatment plan that meets your dental needs, we will also discuss your financial options at your appointment.

We will provide an insurance estimate prior to your treatment, however, it is not a guarantee that your insurance will pay as estimated. We will do our best to see that you receive your full benefits, however, your estimated insurance benefit may differ from the amount paid due to your specific plan coverage. All charges incurred are your responsibility, including fees billed to your insurance company where payment is denied due to your insurance plan's limitations.

Payment for dental service is expected and required at the time of service, unless other arrangments have been made. For your convenience, we accept cash, debit, all major credit cards (Visa, MasterCard, American Express, and Discover), and Care Credit.

Late Patient Policy

Patient who arrive more than fifteen (15) minutes late to their scheduled appointment time may be asked to reschedule as a courtesy to our other scheduled patients.

Patient's Signature: ______________________________ Date: ____________

Parent/Guardian *(if patient is a minor):* ____________________ Relationship To Patient: ____________