Lakeland Hills Dental Care

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1620 Lake Tapps Pkwy SE #130 • Auburn, WA 98092--8376 (253)218-0207

Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **Prev. Visit:** _____ **Email Address:** _____

Phone: _____ _____ _____ _____ **Best time to call:** _____
Home Mobile Work Ext

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Emergency Contact Name & Phone Number

_____

_____

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Morning ☐ Afternoon ☐ Any time

Whom may we thank for referring you to our practice?

☐ Dental Office ☐ Internet ☐ School ☐ Work ☐ Family/ Friend ☐ Other (name below):

Name of person, office, or other source referring you to our practice:

_____

Dental History

Previous Dentist _____

Phone _____

Date of last dental visit _____ **Date of last dental X-rays** _____

Are you dissatisfied with the appearance of your teeth? ◯ Yes ◯ No

If so, why?

_____

_____

Indicate any of the following conditions that apply.

- ☐ Bad Breath
- ☐ Bleeding Gums
- ☐ Clicking or Popping Jaw
- ☐ Food Collection between Teeth
- ☐ Grinding Teeth
- ☐ Loose Teeth or Broken Fillings
- ☐ Periodontal Treatment
- ☐ Sensitivity to Cold
- ☐ Sensitivity to Hot
- ☐ Sensitivity to Sweets
- ☐ Sensitivity to Biting
- ☐ Sores or Growths in mounth

How often do you floss? _____

How often do you brush? _____

Medical History

Physician's Name _____

Physician's Phone _____

Date of last visit _____

Have you had any serious illnesses or operations? ◯ Yes ◯ No

If yes, describe

_____

_____

Have you ever had a blood transfusion? ◯ Yes ◯ No

If yes, give approximate dates

_____

_____

(Women) Are you pregnant? ◯ Yes ◯ No

Nursing? ◯ Yes ◯ No

Taking birth control pills? ◯ Yes ◯ No

Indicate any of the following conditions that apply. *

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Circulatory Problems
- ☐ Chemotherapy
- ☐ Cortisone Treatments
- ☐ Persistent Cough
- ☐ Cough up Blood
- ☐ Diabetes: Last AIC #:_____
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headache
- ☐ Heart Murmur
- ☐ Heart Problems
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Neurological Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Sleep Apnea: CPAP Machine?
- ☐ Stroke
- ☐ Swelling of Feet or Ankles
- ☐ Do you smoke or chew tobacco?
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease
- ☐ Other:

Please list all current medications.

Please list all allergies, including drug allergies.

Do you take antibiotic Premedication for your Dental Visits? If yes, please explain below: * ◯ Yes ◯ No

Preferred Pharmacy & Phone Number:

☐ ***I verify the medical history information provided above to be complete and accurate. I understand that I am responsible for any errors of omissions as well as updating the dentist on any future changes in my medical history.**

Signature _____ **Date** _____

Consent for Services and Financial Agreement

Appointment and Financial Agreement

Canceling/Rescheduling Appointments
-An appointment is a commitment between the doctor and the patient. We have reserved time just for you.
-If you are unable to keep your appointment, we require 24-48 hour advance notice.
-A broken or cancelled appointment with less than 24 hours notice will be subject to a fee of $50 per appointment hour.

Payment
-Full payment is due at the time services are rendered.
-We accept Visa, Mastercard, American Express, Discover, Cash, or Check
-For patients without dental insurance, we offer a courtesy discount if payment is made in full at the time of service.

Insurance
-As a courtesy to our patients, we file insurance claims on your behalf.
-Full estimated co-payment is due at the time of service.
-We do our best to estimate what your out of pocket expense will be, but keep in mind that nothing is guaranteed until payment is received from your insurance.
-After insurance has paid, any remaining balance on your account that is not covered by your insurance is your responsibility.

☐ * **I have read the appointment and financial policy and agree to abide by the terms outlined. I understand and accept my financial responsibilities.**

HIPAA Acknowledgement

The information that we collect from you is only used as allowed by HIPAA (Health Insurance Portability and Accountability Act) and the state of Washington. This includes information relating to your treatments, payments, and for administration purposes. We may use your appointments including, voicemail, answering machines, and postcards. Lakeland Hills Dental Care will never distribute any of your personal information to anyone without your written consent. You may give written authorization for us to disclose your information to anyone you choose.

To ensure that all your records are kept confidential, our policy is to use only secure electronic systems that prevent unauthorized access. We train all our employees to make certain that your records are always confidentially protected. This policy applies to all former, current, and future patients. Your information will never be used for marketing purposes without your consent.

We make sure that we only request personal information that will be necessary to provide standard quality dental care, aid with payment, conduct normal practice operations, and comply with the law. This information may include your full name, address, telephone number, employment information, health records, social security numbers, etc.
Although most information will collected from you, we may obtain information form third parties if necessary. All personal information, regardless of the source, will be protected to the full extent not only by law, but as our standard. However, we are also obligated to provide full information to law enforcement and government officials under special circumstances.

I understand that I may inspect or copy the protected health information described by this authorization.
I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.
I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I allow this practice to disclose my Protective Health Information to the following individuals:

Name and Relationship to Patient:

_____

_____

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Response Date: _____