Greenlake Family Dentistry

4230 Stone Way North
Seattle WA, 98103
(206) 633-3686

Please answer all questions so that we may diagnose your oral health as accurately as possible. All information will be kept strictly confidential. Thank You.

Patients Name: _____ Preferred Name: _____

☐ Male ☐ Female Social Security No. ___ - ___ - ___ Birthdate ___ / ___ / ___

Mailing Address _____

City _____ State _____ Zip Code _____

Home Phone (___) ___ - ___ Cell Phone (___) ___ - ___ Work Phone (___) ___ - ___

Email _____

☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Whom may we thank for referring you? _____

Name of Spouse _____ Social Security No. ___ - ___ - ___ Birthdate ___ / ___ / ___

Patient Occupation _____ Employer _____ Work Phone (___) ___ - ___

Spouse Occupation _____ Employer _____ Work Phone (___) ___ - ___

Primary Dental Insurance	**Secondary Dental Insurance**
Employee _____	Employee _____
Employer _____	Employer _____
Insurance Co. _____ Group # _____	Insurance Co. _____ Group # _____
Employee's S.S. No. ___ - ___ - ___	Employee's S.S. No. ___ - ___ - ___

Person responsible for payment _____

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In case of emergency, whom may we contact?

Name _____ Cell Phone (___) ___ - ___ Work Phone (___) ___ - ___

Relationship to Patient _____

Health History

Patient's Name _____ Date of Birth _____ Base line BP (Clinical Usage) _____

Please Answer all questions by circling Yes (Y) or No (N). * All responses are kept confidential*

1. Has there been any changes in your general health in the past year? ..... Y N
2. Are you under the care of a physician for routine exams or a particular problem?..... Y N
3. Physicians Name _____
   Address _____Phone_____
4. Have you ever had any serious illnesses, operations or hospitalizations? ..... Y N
   Describe, _____
   _____
5. Height _____ Weight_____

6. **Do you HAVE or have you EVER had**:
   - A. Rheumatic Fever or Rheumatic Heart Disease?..... Y N
   - B. Congenital Heart Disease?..... Y N
   - C. Cardiovascular Disease Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, **High Blood Pressure**, Stroke, Palpitations, Heart Surgery, Pacemaker?)..... Y N
   - D. Lung Disease (Asthma, Emphysema, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of breath, Chest Pain, Severe Coughing?) ..... Y N
   - E. Seizures, Convulsions, Epilepsy, Fainting or Dizziness..... Y N
   - F. Bleeding Disorders, Anemia, Bleeding Tendency, Blood Transfusions or Bruise easily?..... Y N
   - G. Liver Disease (Jaundice, Hepatitis **A B C**?) Y N
   - H. Kidney Disease? Y N
   - I. Diabetes? Type I or II ..... Y N
   - J. Thyroid Disease? Hyper/Hypo ..... Y N
   - K. Arthritis? ..... Y N
   - L. Stomach Ulcers or Colitis? ..... Y N
   - M. Glaucoma? ..... Y N
   - N. Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)..... Y N
   - O. Radiation (X-ray) treatment for Cancer..... Y N
   - P. Sinus or Nasal problems? ..... Y N
   - Q. Acid Reflux or GERD ..... Y N
   - R. Aids or HIV ..... Y N
   - S. Sexually Transmitted Diseases? ..... Y N
   - T. Cancer? _____ Y N

7. **Are you using any of the following**:
   - A. Anticoagulants (Blood Thinners)? ..... Y N
   - B. Aspirin or drugs such as Motrin, Aleve, Ibuprofen more than once a week? ..... Y N
   - C. Oral Contraceptives ..... Y N
   - D. Medical or Recreation Marijuana/Cannabis ..... Y N
   - E. Viagra or any vasodilator drug ..... Y N
   - F. Are you taking or ever taken Bisphosphonates (Fosamax, Actonel or other osteoporosis drugs) Y N
   - G. **Please list any and ALL medications including prescription, over-the-counter, herbal, holistic remedies & vitamins:** _____
     _____
     _____

8. **Are you allergic to or have had an adverse reaction to:**
   - A. Local Anesthesia? ..... Y N
   - B. Penicillin or any antibiotics? _____ Y N
   - C. Aspirin or Ibuprofen? ..... Y N
   - D. Codeine or any Pain Killers? ..... Y N
   - F. Latex or Rubber Products? ..... Y N
   - G. Seasonal allergies or sinus trouble? ..... Y N
   - H. Other allergies or reactions? Please list..... Y N
     _____
     _____

9. Do you smoke Tobacco? ..... Y N
   How much? _____
10. Do you chew Tobacco? How much? _____ Y N
11. Do you have any current or past Alcohol or Chemical Dependency or Emotional Disorder? ..... Y N
12. Are you on any special diets? _____ Y N
13. Do you have any other disease, condition or problem not listed? _____
    _____
14. **FOR WOMAN ONLY**
    - A. Are you Pregnant, or is there any chance you might be Pregnant? ..... Y N
    - B. Are you Nursing? ..... Y N

Dental History

1. Do your gums bleed while brushing or flossing? Y N
2. Are your teeth sensitive to hot or cold liquids/food Y N
   Sweet or Sour liquids/ foods Y N
3. Do you feel pain on any of your teeth? Y N
4. Do you have any sores or lumps in or near your mouth? Y N
5. Have you had any injuries to your head, neck or jaw Y N
6. Do you have frequent headaches? Y N
7. Do you clench or grind your teeth? Y N
8. Have you ever experienced any of the following?
   - * Problems in your jaw? Y N
   - * Pain (joint, ear, side of face) Y N
   - * Difficulty opening, closing or chewing? Y N
9. Do you drink more than two sodas/ sports drinks a day? Y N
10. Do you like your smile? Y N

I understand the importance of a truthful Health History to assist the doctor in providing the best care possible and that I will have the opportunity to discuss my Health History with my doctor during this appointment. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform my provider of any changes in my medical status.

Signature _____ **Date** _____

Medical History Update (Staff)

Date _____ Comments _____ Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____ Date _____ Comments _____
Date _____ Comments _____ Date _____ Comments _____ Date _____ Comments _____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the **Statement of Privacy Practices** for Greenlake Family Dentistry. The **Statement of Privacy Practices** describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The **Statement of Privacy Practices** also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The **Statement of Privacy Practices** is also posted in the facility.

Greenlake Family Dentistry reserves the right to change the privacy practices currently 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. I may also obtain a revised **Statement of Privacy Practices** by requesting one be mailed or otherwise transmitted to me.

Personal Health Information Disclosure Agreement

I, _____, do hereby grant permission for Greenlake Family Dentistry, to disclose my personal health information to the following person(s): (spouse, parent, child, friend, etc.)

_____

_____

_____

_____

Information to be disclosed (please check):

- ☐ Appointment dates and times
- ☐ Treatment plans and referrals
- ☐ Financial and billing information
- ☐ Any other pertinent dental health information related to treatment at this office.
- ☐ None of the above

I understand that this permission will remain in effect unless a written cancellation has been provided to Greenlake Family Dentistry.

_____

Name of Patient (please print)

_____ _____

Patient (guardian or representative) Signature Date

_____ _____

Witness Signature Date

Greenlake Family Dentistry Policies

Late Cancellation, No Show Fee Policy

A LATE CANCELLATION or NO SHOW FEE of $100.00 per hour will be charged to all patients who do not provide 48 hour notification to cancel a scheduled appointment. The charge will also apply to patients who miss or "no show" for their scheduled appointment. If a patient late cancels or no shows an appointment three times within a 12 month period, we reserve the right to schedule same day only appointments or terminate the doctor-patient relationship.

Financial Responsibility

New patients must arrive at their scheduled appointment with their insurance card, photo ID and insurance copay if applicable. Co-pays required by a patients insurance plan must be paid at the time of appointment. A $10.00 service fee may be applied when the copay is not paid at the time of the appointment. This fee is in addition to the copay amount owed. If there is a balance remaining after all insurance payments have been received the patient is responsible for payment and will be billed. Patient balances must be paid in full within 30 days of receipt of the patient's statement.

Greenlake Family Dentistry participates in several insurance plans. GFD is participating provider with most Delta Dental, Regence and Premera plans. If the patient has an insurance plan that GFD does not participate in, a claim will still be filed to your insurance as a courtesy. The patient is ultimately responsible for all charges associated with their dental care, regardless of insurance coverage.

If the patient does not have insurance coverage, please be prepared to pay in full at the time of service. Greenlake Family Dentistry does not extend credit. Financial arrangements may be made ahead of time if out of the office financing is needed.

Treatment of a Minor (under age of 18)

If a patient is a minor (or under the age of 18) a parent/guardian of the child must be present at the time new patient appointment. No exceptions. The parent is responsible to ensure payment of patient co-pay due at the time of service. GFD must have signed consent on file or a note signed by the parent/guardian if they do not accompany the minor to their appointments.

Health Insurance Portability and Accountability Act (IIIPAA)

I understand GFD will use and disclose health information about me in compliance with the HIPAA Act. I understand I am entitled to receive a copy of the Notice of Privacy Practices as outlined by Federal Regulations. I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy acknowledges I am aware of my rights in accordance to HIPPA.

By signing this form, I acknowledge that I understand the policies as outlined above. In addition my signature permits GFD to file claims to my insurance (if applicable). I also understand and accept financial responsibility for all services rendered regardless of insurance coverage.

Patient Name:_____ Date:_____

Patient/Guardian Signature:_____