(Office Use only) Chart ID: _____

## Patient Information

Preferred Name:

| | | |
|---|---|---|
| Full First Name: | Last Name: | MI: |
| Address: | | |
| City, State, Zip: | | |

| | |
|---|---|
| Home Phone: | Cell Phone: |
| Work Phone: Ext #: | Email: |
| Birthdate: Age: | □ Patient is the Primary Insurance Policy Holder |
| Social Security: | □ Patient is also the Responsible Party |
| Driver License Number: | □ If not the Responsible Party, please fill out section below. |
| Emergency Contact Name: | Emergency Contact Phone Number: |
| Marital Status (circle): married single divorced separated widowed | |
| Employer: | Employment Status (circle): full time part time retired |
| Names of other family members who are patients here: | How did you hear about our office? |

## Responsible Party

* If someone other than the patient.

| | | |
|---|---|---|
| First Name: | Last Name: | MI: |
| Address, City, State, Zip: | | |

| | |
|---|---|
| Home Phone: | Cell Phone: |
| Work Phone: Ext #: | Email: |
| Employer: | Relationship to Patient: |
| Birthdate: | Social Security Number: |

## Dental Insurance Information

Primary Insurance Company: _____
Subscriber's Name: _____
Employer: _____
ID Number or SS Number: _____
DOB: _____ Group Number: _____

Secondary Insurance Company: _____
Subscriber's Name: _____
Employer: _____
ID Number or SS Number: _____
DOB: _____ Group Number: _____

Patient Signature (Parent if Minor): _____ Date: _____

# Medical History

trio**DENTISTRY**

Patient Name: _____ Age: _____

Name of Physician/and their specialty: _____

Most Recent Physical Examination: _____ Purpose: _____

What is your estimate of your general health? ☐Excellent ☐Good ☐Fair ☐Poor

Are you under a physician's care now? ☐Yes ☐No If Yes, please explain: _____

Have you been hospitalized or had a major operation? ☐Yes ☐No If Yes, please explain: _____

Have you ever had a serious head or neck injury? ☐Yes ☐No If Yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No If Yes, please explain: _____

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No

Are you on a special diet? ☐Yes ☐No If Yes, please explain: _____

Do you smoke cigarettes or use tobacco? ☐Yes ☐No If Yes, please explain: _____

Do you use controlled substances? ☐Yes ☐No If Yes, please explain: _____

Women: Are you pregnant or trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you **ALLERGIC** to any of the following (please circle all that apply):

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other: _____

Do you have, or have had, any of the following:

| | | | |
|---|---|---|---|
| ☐Yes ☐No AIDS/HIV Positive | ☐Yes ☐No Congenital Heart Disorder | ☐Yes ☐No Heart Trouble/Disease | ☐Yes ☐No Psychiatric Care |
| ☐Yes ☐No Alzheimer's Disease | ☐Yes ☐No Cortisone Medicine | ☐Yes ☐No Hemophilia | ☐Yes ☐No Radiation Treatment |
| ☐Yes ☐No Anaphylaxis | ☐Yes ☐No Diabetes | ☐Yes ☐No Hepatitis (type____) | ☐Yes ☐No Recent Weight Loss |
| ☐Yes ☐No Anemia | ☐Yes ☐No Drug Addiction | ☐Yes ☐No Herpes | ☐Yes ☐No Renal Dialysis |
| ☐Yes ☐No Angina | ☐Yes ☐No Easily Winded | ☐Yes ☐No High Blood Pressure | ☐Yes ☐No Rheumatic Fever |
| ☐Yes ☐No Arthritis/Gout | ☐Yes ☐No Emphysema | ☐Yes ☐No High Cholesterol | ☐Yes ☐No Scarlet Fever |
| ☐Yes ☐No Artificial Heart Valve | ☐Yes ☐No Epilepsy or Seizures | ☐Yes ☐No Hives or Rash | ☐Yes ☐No Shingles |
| ☐Yes ☐No Artificial Joint | ☐Yes ☐No Excessive Bleeding | ☐Yes ☐No Hypoglycemia | ☐Yes ☐No Sinus Trouble |
| ☐Yes ☐No Asthma | ☐Yes ☐No Excessive Thirst | ☐Yes ☐No Irregular Heartbeat | ☐Yes ☐No Gastrointestinal Disease |
| ☐Yes ☐No Blood Disease | ☐Yes ☐No Fainting Spells/Dizzy | ☐Yes ☐No Jaundice | ☐Yes ☐No Stroke |
| ☐Yes ☐No Blood Transfusion | ☐Yes ☐No Frequent Cough | ☐Yes ☐No Kidney Problems | ☐Yes ☐No Swelling of Limbs |
| ☐Yes ☐No Breathing Problem | ☐Yes ☐No Frequent Headaches | ☐Yes ☐No Leukemia | ☐Yes ☐No Thyroid Disease |
| ☐Yes ☐No Bruise Easily | ☐Yes ☐No Glaucoma | ☐Yes ☐No Liver Disease | ☐Yes ☐No Tonsilitis |
| ☐Yes ☐No Cancer | ☐Yes ☐No Hay Fever | ☐Yes ☐No Low Blood Pressure | ☐Yes ☐No Tuberculosis |
| ☐Yes ☐No Chemotherapy | ☐Yes ☐No Heart Attack/Failure | ☐Yes ☐No Lung Disease | ☐Yes ☐No Tumors or Growths |
| ☐Yes ☐No Chest Pains/Angina | ☐Yes ☐No Heart Murmur | ☐Yes ☐No Osteoporosis | ☐Yes ☐No Ulcers |
| ☐Yes ☐No Cold Sores | ☐Yes ☐No Heart Pacemaker | ☐Yes ☐No Pain in Jaw Joints | ☐Yes ☐No Venereal Disease |
| ☐Yes ☐No Convulsions | | ☐Yes ☐No Parathyroid Disease | |

Please explain any YES answers above: _____

Have you ever had any serious illness not listed above: ☐Yes ☐No If yes, please name:_____

Describe any current medical treatment, impending surgery or other treatment that may affect your dental treatment:

_____

List any medications, supplements, and/or vitamins you are currently taking:

| Drug | Purpose | Drug | Purpose |
|---|---|---|---|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform trioDENTISTRY of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date:_____

# Dental History

trio**DENTISTRY**

Patient Name: _____ Today's Date: _____

What is the main reason for your visit today? _____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-Rays: _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____

Previous Dentist's Phone: _____ Previous Dentist's City, State: _____

Reason for Leaving: _____

How often do you have dental examinations? _____ Brush?_____times/day Floss? _____

Have you ever used, or currently use, topical fluoride? _____

What other dental aids do you use? (i.e waterpik, airfloss, toothpick etc.) _____

**Do you have any dental problems or pain now? YES NO**

If yes, please describe: _____

| | | | | | |
|---|---|---|---|---|---|
| Are any of your teeth sensitive to hot or cold? | Yes | No | Have you ever had: | | |
| Are any of your teeth sensitive to sweets? | Yes | No | Braces or orthodontic treatment? | Yes | No |
| Are any teeth sensitive to biting or chewing? | Yes | No | Extractions or oral surgery? | Yes | No |
| Have you noticed any mouth odors or bad taste? | Yes | No | Gum surgery or periodontal treatment? | Yes | No |
| Do you get cold sores, blisters, or other oral lesions? | Yes | No | Your bite adjusted or teeth grinded? | Yes | No |
| Do your gums bleed or hurt? | Yes | No | A nightguard or other mouthguard? | Yes | No |
| Have your parents had gum disease or tooth loss? | Yes | No | A serious injury to the mouth or head? | Yes | No |
| Have you noticed any loose teeth? | Yes | No | Clicking or popping of the jaw? | Yes | No |
| Does food often get caught in between your teeth? | Yes | No | Pain (joint, ear, side of face)? | Yes | No |
| If yes, where: _____ | | | Difficulty in opening or closing, or locked jaw? | Yes | No |
| | | | Difficulty chewing on either side of the mouth? | Yes | No |
| Do you: | | | Constant headaches? | Yes | No |
| Clench or grind your teeth while awake or asleep? | Yes | No | Sore muscles (neck, shoulders)? | Yes | No |
| Bite your lip or cheek regularly? | Yes | No | | | |
| Hold foreign objects with your teeth (pen,nails,etc)? | Yes | No | Are you satisfied with your teeth's appearance? | Yes | No |
| Mouth breathe while awake or asleep? | Yes | No | Would you like to improve the look of your smile? | Yes | No |
| Have tired jaw muscles, especially when you wake? | Yes | No | Have you ever bleached or whitened your teeth? | Yes | No |
| Snore or have any other sleeping disorders? | Yes | No | Do you take pre-medication before dental treatment? | Yes | No |
| Smoke/chew tobacco or use any tobacco products? | Yes | No | | | |

**Do you feel nervous about having dental treatment? Yes No**

If yes, please describe: _____

**Have you ever had trouble getting numb or a reaction to local anesthetics? Yes No**

If yes, please describe: _____

**Is there anything else you would like us to know for your dental visit? Yes No**

If yes, please explain: _____

_____

Patient or Guardian Signature: _____

# Financial Policy

trio**DENTISTRY**

We are committed to providing you with the best and most comprehensive dental care. Please read this form carefully:

DENTAL INSURANCE

If you have dental insurance, we are more than happy to file the appropriate claim forms to your insurance company as a courtesy to you. If your insurance denies coverage, the amount will then become due and payable by you. Your coverage is a contract between you and your insurance company. Although we will make every possible effort to help you obtain your maximum benefits, we CANNOT GUARANTEE that your insurance company will pay and you will be responsible for any amount they do not cover.

> *The amount of your patient portion we ask for is always only an **ESTIMATE**, as insurance companies often cannot or will not provide exact fee coverage amounts. You will be billed and responsible for any amount that differs from the patient estimate.

FEE & PAYMENT POLICY

1. Payment of the estimated patient portion is due at the time of service. We accept cash, personal check or credit card.
2. A down payment may be required to reserve an appointment with the Doctor for all complex restorative, cosmetic or surgical cases, regardless of insurance coverage.
3. A 5% courtesy discount is offered to our patients without dental insurance who pay by cash or check. May not be combined with additional discounts.
4. A 10% senior citizen discount is offered to all of our patients age 65+ who do not have dental insurance. May not be combined with additional discounts.
5. Membership Club discounts may not be combined with additional discounts.
6. Accounts over 60 days may be charged a 1.5% monthly fee.
7. Accounts over 90 days may be assigned to a collections company.

APPOINTMENT RESERVATION POLICY

An appointment is a valuable, designated period of time set aside for the care of our patients. While we understand that unforeseen circumstances arise and plans may change, we request a **MINIMUM OF 48 BUSINESS HOURS NOTICE** if you are unable to keep your appointment.

**If less than 48 BUSINESS HOURS NOTICE is given, a $75 per appointment hour charge may be implemented for a failed or late cancelled appointment. By signing below, I acknowledge that I fully understand and agree to this financial policy.**

_____ _____

Print Patient Full Name | Signature of Responsible Party | Date

RESPONSIBILITY AS OUR PATIENT

I acknowledge my responsibility for payment of services rendered by trioDENTISTRY in accordance with the fees and terms of this financial policy. I understand that I have the final responsibility for payment of all fees for any services rendered and that it is my responsibility whether or not insurance (or any third party) pays for all, part, or none of the charges.

**By signing below, I acknowledge that I fully understand and agree to this financial policy.**

_____ _____

Print Patient Full Name | Signature of Patient (or Parent/Guardian)

_____ _____

Print Parent/Guardian Full Name if applicable | Date

*Parent/Guardian is responsible financially for Patient

THANK YOU! WE LOOK FORWARD TO CARING FOR YOUR DENTAL HEALTH!

# Acknowledgement of Privacy Practices

trio**DENTISTRY**

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**trioDENTISTRY**
13302 39th Ave SE Ste 101
Mill Creek, WA 98012
p. 425.338.9183

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act (HIPAA). I have been informed of my dental provider's "Notice of Privacy Practices" which contains a description of the uses and disclosures of my protected health information. I have been given the right to review and/or receive a copy of such "Notice of Privacy Practices", which trioDENTISTRY has a copy accessible to any patient. I understand that my dental provider has the right to change the "Notice of Privacy Practices" and that I may contact this office at the practice address above to obtain a current copy.

**I understand that this information can and will be used to:**

☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly or indirectly.

☐ Obtain payment from third-party payers for my health care services.

☐ Conduct normal health care operations such as quality assessment and improvement activities.

I understand that I may request in writing that you restrict how my private information is used or disclosed for treatment, payment, or health care operations. I understand that you (dental provider) are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____________________________________________ Date: _____________________

Print Patient Name: _________________________________________________________________

Relationship to Patient (if other than self): __________________________________________________

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

For office use only:

We were unable to obtain the patient's written acknowledgement of our "Notice of Privacy Practices" due to the following:

____ The patient refused to sign
____ Communication barriers
____ Emergency situation
____ Other: _______________________________________