Patient Registration

Today's Date:	Preferred Nickname:

Legal Name: Last:	First:	Middle:	Social Security #:

Date of Birth:	Age:	Sex: ☐ M ☐ F	Preferred Gender Pronoun ☐ Male/He ☐ Female/She ☐ Other/They/Them

Address:	City:	State:	Zip:

Occupation:	Employer:

Cell Phone:	Home Phone:	Email:

How did you hear about us?

Other family members seen here:

Emergency Contact Name:	Relationship:	Cell Phone:	Other Phone:

Dental Insurance Information *(Please give your insurance card to the receptionist)*

Subscriber's Name:	Date of Birth:	SSN:	Phone:
Is this person a patient here? ☐ Yes ☐ No	Address (if different):	Dental Insurance Company:	Group #:

What is the reason for your dental visit today?
☐ *Routine Visit* ☐ *Pain* ☐ *Swelling* ☐ *Bleeding* ☐ *Smile Concerns* ☐ *Trauma* ☐ *Other* ___________

Why did you leave your last dentist? ☐ *Referring Doctor*__________ ☐ *Other*___________________________

Any history of dental anxiety? **Y / N** *Low* *Moderate* *High* If yes, please explain: __________________

Date of your last dental exam and/or cleaning: __________ Date of your last dental x-rays: ____________

What in life gives you enjoyment? ☐ *Music* ☐ *Reading* ☐ *Animals* ☐ *Children* ☐ *Working* ☐ *Exercise*
☐ *Other* ____

MEDICAL HISTORY

Joint Replacement:
Have you had an orthopedic total joint replacement? **Y / N** **DATE:**

Heart Valve:
Have you had an artificial heart valve placed or history of infective endocarditis? **Y / N** **DATE:**

Women: Are you pregnant? **Y / N** *Week #*_____________ Are you breastfeeding? **Y / N**

Tobacco use: *Past* *Current* **Type:** *Cigarettes* *Cigars* *Smokeless/Chewing* *Pipe* *Vape* *Marijuana* *Other (please list):*

Medications. Please list all medications and supplements. ☐ Check here if no medications	**Allergies.** Are you allergic to or had any past reaction to: ☐ Check here if no known allergies	
		Penicillin
		Acrylic
		Latex (rubber)
		Sulfa drugs or other antibiotics
		Anesthetics
		Animals
		Codeine or other narcotics
		Aspirin
		Hay fever/Seasonal
		Barbituates, sedatives, sleeping pills
		Food
		Metals
		Other

	HEALTH CONDITIONS				☐ CHECK HERE if you have none of the below conditions
	Cardiovascular Disease		Autoimmune disease		Stroke
	Chest Pain/Angina		Systemic Lupus		Hypo/Hyper Thyroidism
	Arteriosclerosis		Rheumatoid Arthritis		Glaucoma
	Congestive Heart Failure		Osteoarthritis		Hepatitis, Jaundice, or Liver disease
	Damaged Heart Valves		Asthma		Epilepsy/Seizures
	Heart Attack		Bronchitis		Fainting Spells
	Heart Murmur		Emphysema		Neurological Disorder *Specify:* ______________
	High / Low Blood Pressure		Sinus trouble		
	Congenital Heart Defect		Tuberculosis		Sleep Disorder
	Arrhythmia/Irregular Heartbeat		Cancer, Chemotherapy, and/or Radiation Treatment		Mental Health Disorder *Specify:* _____________
	Mitral Valve Prolapse		Chest Pain upon Exertion		
	Pacemaker		Chronic Pain		Recurrent Infection
	Rheumatic Fever		Diabetes *Type I* *or* *Type II*		Kidney Problems
	Alcohol/Drug Use				Osteoporosis
	Abnormal Bleeding		Eating Disorder		Swollen glands in neck
	Anemia		Gastrointestinal Disease		Severe headaches/migraines
	Hemophilia		G.E. Reflux or Heartburn		STDs
	Excessive Urination		Ulcers		AIDS or HIV Infection
	High Cholesterol		Severe or rapid weight loss		Cold sores/Herpes

Do you have any disease, condition, or problem not listed above?
Please explain:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me safely and effectively. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I hereby grant permission to the doctor to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis of my dental care. I understand any photographs may be used for documentation and for educational purposes.

Signature of Patient/Legal Guardian:	Date:

Office & Financial Policy

At our dental practice, the payment of your bill is part of your treatment, and we kindly request payment at the time services are provided. As your dedicated dental care provider, our relationship is with you, our patient, and not with your insurance company. As a courtesy to you, we will submit all insurance claims to your insurance provider and provide you with an **estimate** of the portion they will cover. However, please remember that you are responsible for all charges incurred, regardless of insurance coverage.

Once your insurance pays its portion, we will send you a statement for any remaining balance, which is due upon receipt. In case your insurance has not made payment within 60 days, the unpaid balance becomes your responsibility and may be subject to finance charges for the collection process. If you should require assistance with financial arrangements, we require these arrangements to be made prior to your treatment appointment.

Credit Card Policy. Credit card payments will be allowed up to $1,000 with no additional fees. For any amount over $1,000, an additional 3% credit card processing fee will be applied to your account. To avoid the processing fee, we do accept checks or cash.

Cancellation & Late Policy. Your appointment time is reserved for you. If you are running late for your appointment, please contact us to see if we can accommodate you or reschedule for a different day/time. Minimum 48 hours advanced notice is required for cancellations, and notifications can be left on our answering machine after business hours. Missed appointments will incur a $125.00 charge per hour reserved for your treatment, and appointments exceeding two hours require a $250 reservation deposit. If you keep your scheduled appointment, this deposit may be credited towards your treatment.

Cancelled Checks and Past Due Balances. All returned checks are subject to $35 fee, and balances over 60 days will accrue interest at 18% annum. In the event of an unpaid account with past due balances, we may report it to all three major credit bureaus and assign it to a Collections Agency.

I have read and accept the terms of the above Financial Policy and Agreement and understand that I am fully responsible for payment of fees incurred regardless of any insurance.
I have authorized Bothell Smiles Family Dentistry to bill my dental insurance company and accept assignment of my dental benefits.

Signature of Patient/Legal Guardian:	Date:

Privacy Policy

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
A copy of the Notice of Privacy Practices is available for your review at any time you request.

I, (please print name) ____, have received a copy of this office's **Notice of Privacy Practices**.

Signature of Patient/Legal Guardian:	Date: