LANEY DENTAL

Patient Information

We are pleased that you have selected us to provide for your dental care. Please complete the following forms, including: patient information, medical history, dental history, privacy practices and our financial agreement. This information is necessary for our files to best treat you and will be considered confidential.

Purpose of Visit:_____ Date:_____

PATIENTS NAME:_____ **PREFERRED NAME:**_____

Date of Birth:_____ Age: _____ Patient is: __Married __Single __ Widowed __Clergy

Day Phone: (_____)_____ Cell Phone: (_____)_____Email:_____

Address:_____ City, State, ZIP_____

Employed By: _____ Occupation: _____ How long?_____

Financially Responsible Person:_____ Relationship:_____

Address:_____ City, State, ZIP:_____

Day Phone: (_____)_____ Cell Phone: (_____)_____

In case of an emergency, whom may we contact? *(Other than someone living with you)*

Emergency Contact Person: _____ Relationship:_____

Day Phone: (_____)_____ Cell Phone: (_____)_____

Dental Insurance:

Insurance Company:_____ Member/Subscriber ID #:_____

Group: _____ Group #:_____ Relationship to Patient:_____

Insurance Company Phone #: (_____)_____

Whom may we thank for referring you?

_____

Other Doctors: *Your prior dental experiences are of great value to us in assessing your present problem and determining to whom you would like to be referred should specialized care be required. Also, whom to contact in case of questions regarding treatment history assisting in future care. Please list names of the following health care professionals who have or are now caring for you.*

General Dentist: _____ Prosthodontist: _____

Endodontist: _____ Oral Surgeon: _____

Orthodontist: _____ Periodontist: _____

Personal Physician: _____ Other: _____

4001 COLBY AVE
EVERETT WA 98201
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Medical History

These questions are for your benefit and ensure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are all associated with proper oral health.

Have you been hospitalized or seen a medical doctor in the past 2 years?
*If so, for what condition?*_____
Physicians Name:_____
Date of Last Visit: _____

Are you currently taking any prescriptions, over the counter or herbal supplements? __Yes __No
If so, please list and reason for taking
_____
_____
_____
_____

Any bone density medication or Bisphosphonates? (*Aredia, Zometa, Fosamax, Acetonel, etc.)* __Yes __No
If you answered yes please list below
Name of medication:_____
Date started: _____

Do you take blood thinners? __Yes __No
If you answered yes please list below
Name of medication: _____
Date started:_____

Do you smoke, vape or use chewing tobacco?
If you answered yes, circle one __Yes __No

WOMEN: Are you pregnant or nursing? __Yes __No

Do you now have or have you had any of the following *(please check known conditions)*:

__ Allergies or Hives
__ Anemia
__ Angina Pectoris
__Arthritis
__Artificial Prosthesis
__ Asthma
__Blood Disease
__Bruise Easily
__Cerebral Palsy
__Chemotherapy
__Cancer or Leukemia
__Cold Sores
__Diabetes (I, II)
__ High Blood Pressure
__ Emphysema
__ Epilepsy or Seizures
__ Excessive Bleeding
__ Fainting Spells
__ Glaucoma
__ Hay Fever
__ Head Injury
__ Heart Aliments/ Attack
__ Heart Failure
__ Heart Murmur
__ Hemophilia
__ Hepatitis (A, B, C)
__ Drug/ Alcohol Addiction
__ Other:_____
__ HIV or AIDS
__ Joint replacement
__Kidney Disease
__Liver Disease
__Mental Disorder
__Nervous Disorder
__ Osteoporosis
__ Psychiatric Treatment
__ Radiation
__Respiratory Disease
__Rheumatic Fever
__Congenital Heart Lesions
__ High Cholesterol
__ Rheumatism
__ Sickle Cell Disease
__ Sinus Problems
__Stomach Ulcers
__ Stroke
__Thyroid Disease
__ Tuberculosis (TB)
__ Tumors/ growths
__Venereal Disease
__Xray Treatment
__Cobalt Treatment
__Eating Disorder(s)

Are you allergic or have you reacted adversely to any of the following? *(Please check any that apply)*

__Codeine __Triazolam __Percodan __Tylenol __Percodan __Valium
__Aspirin __Sulfa __Ibuprofen __Penicillin __Erythromycin __ Tetracycline
__Latex __Metals __Amoxicillin **__No Allergies**

List any other allergies here: _____

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Dental History

Most Recent Dental Exam:_____ Most recent X-ray:_____
How often do you get your teeth cleaned? _____3 months _____ 6 months _____1 year

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____

Please answer yes or no to the following:

1. Are you unhappy with the appearance of your teeth? ..... __Yes __No
2. Have you had unfavorable dental experiences? ..... __Yes __No
3. Do you have dental fear(s)? ..... __Yes __No
4. Problems with effectiveness or bad reactions to dental anesthetic? ..... __Yes __No
5. Have you had orthodontic (braces) treatment? ..... __Yes __No
6. Periodontal (gum) treatment? If so, when?_____ ..... __Yes __No
7. Do your gums bleed? ..... __Yes __No
8. Do you avoid brushing any parts of your mouth? ..... __Yes __No
9. Is part of your mouth sensitive to temperature? ..... __Yes __No
10. Do you have sore teeth? ..... __Yes __No
11. Do you ever have a burning sensation in your mouth? ..... __Yes __No
12. Do you have a difficulty swallowing? ..... __Yes __No
13. Do you have an unpleasant taste or odor in your mouth? ..... __Yes __No
14. Do you have dry mouth, throat or eyes? ..... __Yes __No
15. Do you have a sore jaw? ..... __Yes __No
16. Do you have difficulty opening your mouth widely? ..... __Yes __No
17. Do you have stiff neck muscles? ..... __Yes __No
18. Do you get tension headaches? ..... __Yes __No
19. Do you clench or grind your teeth? ..... __Yes __No
20. Does your jaw every 'click' or 'pop'? ..... __Yes __No
21. Have you lost any teeth? ..... __Yes __No

If you currently have dentures *(check all that apply):*

_____Complete Denture(s) _____Partial Denture(s)
When did you receive your first complete or partial denture? _____
How long have you worn your current complete or partial denture? _____
Has your current denture ever been relined?_____When?_____
Is your current denture a problem?_____Describe:_____
Are you satisfied with the appearance? __Yes __No
Are you satisfied with the comfort? __Yes __No
Are you satisfied with your ability to chew? __Yes __No

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held at the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status or medications.

Patient Signature: _____ **Date:**_____

Practitioners Signature: _____**Date Reviewed:**_____

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LANEY DENTAL

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the STATEMENT OF PRIVACY PRACTICES for the office of *Laney Dental.* The STATEMENT OF PRIVACY PRACTICES describes the types of uses and disclosures of my protected health information and 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 right and the responsibilities and duties of the office with respect to my protected health information. The STATEMENT OF PRIVACY PRACTICES is also posted in the facility.

Laney Dental reserves the right to change the prvacy practices that are 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 that one be mailed to me.

ADITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the STATEMENT OF PRIVACY PRACTICES, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

1._____ Relationship to Patient:_____

2._____ Relationship to Patient: _____

3._____ Relationship to Patient: _____

_____ **X**_____

(Name of patient or personal representative) *(Signature of patient or personal representative)*

Date:_____

(For Office Use Only)

RECORD OF AWKNOWLEDGEMENT NOT OBTAINED:

Provided Prior to Treatment: __Yes __No Date Provided:_____

Reason for Denial:
__Needed more time to review statement
__Wanted to consult with another person
__Reason not given
__Other

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LANEY DENTAL

Financial Agreement & Estimate of Services

We would like to welcome you to our dental office and inform you of our policy regarding fees.

For Our Patients with Dental Coverage:

I understand that I am financially responsible for all the charges whether paid by my insurance or not. I understand that my treatment plan is ***only an estimate*** of what my insurance may pay***. This is not a guarantee of payment from my insurance company***. Fees vary with type of service and complexity of treatment. I understand that estimated payment for services is due at the time services are rendered. If the insurance company refuses payment, nor does not pay in full or the full estimated amount, I understand I am responsible for the remaining outstanding balance.

For Our Patients Without Dental Coverage:

Payment is due at the time services are rendered.

Unpaid Balances:

I understand that if I do not pay my bill, collection action may be taken, and I will be responsible for paying any collection and legal fees. Should collection become necessary, the responsible party agrees to pay an additional 30% collection fee, and all legal fees of collection with or without suit, including legal and court costs.

Description of Services to be Provided (*these can change after the exam*):

1._____ 2._____

3._____ 4._____

Estimate of Insurance Payment: **Estimate of Patient Out of Pocket:**

_____ _____

By signing below, I indicate my understanding and acceptance of these financial policies.

_____ **X**_____

Patients name (printed) *Patients signature*

Date:_____

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