Patient Registration

ID:_____ Chart ID:_____

First Name:_____ Last Name:_____ Middle Initial:_____

Patient is: ☐ Policy Holder ☐ Responsible Party Preferred Name: _____

Responsible Party (if someone other than the patient)

First Name:_____ Last Name:_____ Middle Initial:_____

Address:_____ Address 2:_____

City, State, Zip:_____ _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Birth Date:_____ Soc. Sec:_____ Drivers Lic:_____

◯ Responsible Party is also a Policy Holder for Patient ◯ Primary Insurance Policy Holder ◯ Secondary Insurance Policy Holder

Patient Information

Address:_____ Address 2:_____

City:_____ State / Zip:_____ _____

Home Phone:_____ Work Phone:_____ Ext:_____ Cellular:_____

Sex: ◯ Male ◯ Female Marital Status: ◯ Married ◯ Single ◯ Divorced ◯ Separated ◯ Widowed

Birth Date:_____ Age:_____ Soc. Sec:_____ Drivers Lic:_____

E-mail:_____ ☐ I would like to receive correspondences via e-mail.

Section 2

Employment Status: ◯ Full Time ◯ Part Time ◯ Retired

Student Status: ◯ Full Time ◯ Part Time

Medicaid ID:_____ Pref. Dentist:_____

Employer ID:_____ Pref. Pharmacy:_____

Carrier ID:_____ Pref. Hyg:_____

Section 3

Referred By:_____

Previous Dentist:_____

Emergency Contact:_____

Emergency Contact #:_____

Primary Insurance Information

Name of Insured:_____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec:/ID#_____ Insured Birth Date:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Rem. Deduct:_____.00 Rem. Deduct:_____.00

Secondary Insurance Information

Name of Insured:_____ Relationship to Insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insured Soc. Sec/ID#_____ Insured Birth Date:_____

Employer:_____ Ins. Company:_____

Address:_____ Address:_____

Address 2:_____ Address 2:_____

City, State, Zip:_____ City, State, Zip:_____

Rem. Deduct:_____.00 Rem. Deduct:_____.00

Medical History

Birth Date_____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Heath problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

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

Have you ever 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:_____

Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain:_____

Do you take, or have you taken Phen-Fen or Redux? ◯ Yes ◯ No

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

Are you on a special diet? ◯ Yes ◯ No

Do you use tobacco? ◯ Yes ◯ No

Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯Yes ◯No	Cortisone Medicine ◯Yes ◯No	Hemophilia ◯Yes ◯No	Renal Dialysis ◯Yes ◯No
Alzheimer's Disease ◯Yes ◯No	Diabetes ◯Yes ◯No	Hepatitis A ◯Yes ◯No	Rheumatic Fever ◯Yes ◯No
Anaphylaxis ◯Yes ◯No	Drug Addiction ◯Yes ◯No	Hepatitis B or C ◯Yes ◯No	Rheumatism ◯Yes ◯No
Anemia ◯Yes ◯No	Easily Winded ◯Yes ◯No	Herpes ◯Yes ◯No	Scarlet Fever ◯Yes ◯No
Angina ◯Yes ◯No	Emphysema ◯Yes ◯No	High Blood Pressure ◯Yes ◯No	Shingles ◯Yes ◯No
Arthritis/Gout ◯Yes ◯No	Epilepsy or Seizures ◯Yes ◯No	Hives or Rash ◯Yes ◯No	Sickle Cell Disease ◯Yes ◯No
Artificial Heart Valve ◯Yes ◯No	Excessive Bleeding ◯Yes ◯No	Hypoglycemia ◯Yes ◯No	Sinus Trouble ◯Yes ◯No
Artificial Joint ◯Yes ◯No	Excessive Thirst ◯Yes ◯No	Irregular Heartbeat ◯Yes ◯No	Spina Bifida ◯Yes ◯No
Asthma ◯Yes ◯No	Fainting Spells/Dizziness ◯Yes ◯No	Kidney Problems ◯Yes ◯No	Stomach/Intestinal Disease ◯Yes ◯No
Blood Disease ◯Yes ◯No	Frequent Cough ◯Yes ◯No	Leukemia ◯Yes ◯No	Stroke ◯Yes ◯No
Blood Transfusion ◯Yes ◯No	Frequent Diarrhea ◯Yes ◯No	Liver Disease ◯Yes ◯No	Swelling of Limbs ◯Yes ◯No
Breathing Problems ◯Yes ◯No	Frequent Headaches ◯Yes ◯No	Low Blood Pressure ◯Yes ◯No	Thyroid Disease ◯Yes ◯No
Bruise Easily ◯Yes ◯No	Genital Herpes ◯Yes ◯No	Lung Disease ◯Yes ◯No	Tonsillitis ◯Yes ◯No
Cancer ◯Yes ◯No	Glaucoma ◯Yes ◯No	Mitral Valve Prolapse ◯Yes ◯No	Tuberculosis ◯Yes ◯No
Chemotherapy ◯Yes ◯No	Hay Fever ◯Yes ◯No	Pain in Jaw Joints ◯Yes ◯No	Tumors or Growths ◯Yes ◯No
Chest Pains ◯Yes ◯No	Heart Attack/Failure ◯Yes ◯No	Parathyroid Disease ◯Yes ◯No	Ulcers ◯Yes ◯No
Cold Sores/Fever Blisters ◯Yes ◯No	Heart Murmur ◯Yes ◯No	Psychiatric Care ◯Yes ◯No	Venereal Disease ◯Yes ◯No
Congenital Heart Disorder ◯Yes ◯No	Heart Pace Maker ◯Yes ◯No	Radiation Treatments ◯Yes ◯No	Yellow Jaundice ◯Yes ◯No
Convulsions ◯Yes ◯No	Heart Trouble/Disease ◯Yes ◯No	Recent Weight Loss ◯Yes ◯No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No

If yes, please explain:_____

Comments:_____

_____

_____

_____

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

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN_____Date:_____

Patient Practice Agreement

Thank you for choosing West Vancouver Dental for your dental needs. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options

We accept:

- Cash, Check, Visa, MasterCard, American Express and Discover Card
- Third Party Payment Plans[1] from Care Credit and Lendingtree

West Vancouver Dental requires payment at the time of service. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received.

A $35 fee will be charged for all returned checks.

Dental Insurance

Dental Insurance plans are a contract between the patient and the insurance provider. It is your responsibility to know your benefit plan. As a courtesy for our patients with dental insurance, we are happy to help you understand the limitations to your benefit plan. West Vancouver Dental is happy to work with your insurance carrier to maximize your benefits and bill them directly for reimbursement of your treatment. West Vancouver Dental will handle all claims for 60 days. If we have not received a response from your insurance provider after 60 days, any further handling of the claim becomes the patient's responsibility. All treatment plans provided by West Vancouver Dental are estimated insurance coverage – not a guarantee of payment by the insurance provider. _____ *patient initials*

Appointments

At West Vancouver Dental your appointment is made in advance by reserving the appropriate amount of time to accommodate you, and the treatment being performed. Our staff spends meticulous time preparing for each appointment by sterilizing, organizing, and arranging the set ups prior to your arrival. We respectfully ask for scheduled appointments to be canceled at least 24 hours in advance. When a patient does not show up for a scheduled appointment, another patient loses an opportunity to be seen. There will be a fee of $75.00/scheduled hour applied to your account if we do not receive a call 24 hours prior to your appointment to cancel. This policy will enable us to open otherwise unused appointments to better serve the needs of all patients. Any patient who shows up 15 minutes late to their scheduled appointment will be considered a no show. Patients who miss more than 2 scheduled appointments may be dismissed from the practice. _____ patient initials

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Patient, Parent or Guardian Signature Date

Patient Name(PleasePrint)

[1] Subject to credit approval.

Notice of Privacy Practices Acknowledgment

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the office of West Vancouver Dental.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed and also how you can access you information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

Patient Name (Printed) Date

Patient's or Legally authorized individual (Signature)

Printed name if signed on behalf of the patient

This form will be retained in your medical records
Last Update:_____/_____/_____

CONSENT TO RELEASE / REQUEST DENTAL RECORDS

I, _____, do hereby consent and authorize _____
(Patient name) ***(Previous Dental Office)***

To disclose to West Vancouver Dental information in my record, including current and previous dental records from other practitioners, hospitals and/ or clinics which are part of my record.

My date of birth is _____.
This information is strictly for the purpose of identification.

I also consent to the release of dental records by West Vancouver Dental in the event any additional information is needed by my insurance company or other providers.

Patient or guardian signature: _____
Print: _____
Relationship to patient: _____
Date: _____

Please send this to:
West Vancouver Dental
117 E 39th Street
Vancouver, WA 98663

Digital X-Rays can be e-mailed to: info@westvancouverdental.com

If you have any questions, please call our office: (360) 694-7931

Copies of the following records are specifically requested:

- ☐ Progress notes
- ☐ Letters/Reports to/from Specialist
- ☐ Periodontal Charting
- ☐ Radiographs
- ☐ Medical History Forms