Dr Steven Ash & Dr Brian Roberts
2409 Borst Avenue
P.O. Box 1660
Centralia, WA 98531
(360)736-8380

Please help us by completing this form. The better we communicate, the better we can care for you.

Confidential Patient Information

Name: _____
LAST FIRST MIDDLE INITIAL

Address : _____
STREET

_____
CITY STATE ZIP

Phone: Home: _____ Cell: _____ E-mail address: _____

Confirm Appointments at (check): ☐Home ☐ Work ☐Cell ☐E-mail

Date of Birth:_____ □ Under age 18 Social Security #: _____

Patient Employer & Address: _____

Occupation: _____ Work Phone: _____ OK To Call Work: □ YES □ NO

Marital Status: □ Married □ Single □ Divorced □ Widowed

Spouse/ Parent or Guardian Name: _____
LAST FIRST MIDDLE INITIAL

Spouse / Parent or Guardian Employer & Address: _____

Occupation: _____ Work Phone: _____ OK To Call Work: □ YES □ NO

In case of an emergency: Name: _____ Home: _____ Other: _____

Relationship: _____ Other Family Members seen by us: _____

Insurance

Insurance Coverage: □ Yes □ No

Insurance Co.: _____
Subscriber Name: _____
Subscriber DOB: _____
Social Security #: _____

Relation to patient: _____
Employer: _____
Group #:_____

Secondary Insurance Coverage: □ Yes □ No

Insurance Co.:_____
Subscriber Name: _____
Subscriber DOB: _____
Social Security #: _____

Relation to patient: _____
Employer: _____
Insurance Co. Group #:_____

Insurance Authorization Statement
I hereby authorize release of information necessary to file a claim with my insurance company, and assign benefits otherwise payable to me to Dr Steven Ash and/or Dr Brian Roberts as indicated on the claim.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. I understand that I am responsible for all costs and dental treatment. In the event legal action should become necessary to collect any unpaid balance for services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. I agree that the venue for any legal action shall be Lewis County. The information on this page is correct to the best of my knowledge.

_____ _____ _____
Patient or Guardian Signature Relation to patient Date

Verify ID _____ Staff Entered_____

Dental History

PATIENT NAME _____

Previous Dentist _____ How long _____

Most recent dental exam_____ Most recent dental x-rays _____

Most recent dental treatment _____

How often do you have you teeth cleaned? 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 1 year or longer ☐

WHAT IS YOUR IMMEDIATE DENTAL CONCERN? _____

Dental History Update

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	YES	NO
1. Unhappy with the appearance of your teeth	☐	☐
2. Unfavorable dental experiences	☐	☐
3. Dental fears	☐	☐
4. Problems with effectiveness or bad reactions to dental anesthetic	☐	☐
5. Orthodontic treatment (braces), when _____	☐	☐
6. Periodontal (gum) treatment, when _____	☐	☐
7. Bleeding gums	☐	☐
8. Avoid brushing any part of your mouth	☐	☐
9. Part of your mouth is sensitive to temperature	☐	☐
10. Sore teeth	☐	☐
11. A burning sensation in your mouth	☐	☐
12. Difficulty swallowing	☐	☐
13. An unpleasant taste or odor in your mouth	☐	☐
14. Dry mouth, throat, and or eyes	☐	☐
15. Jaw problems (temporomadibular joint)	☐	☐
16. Difficulty opening your mouth widely	☐	☐
17. Stiff neck muscles	☐	☐
18. Awaken with an awareness of your teeth or jaws	☐	☐
19. Tension headaches	☐	☐
20. Clench or grind your teeth	☐	☐
21. Jaw clicking or jaw popping	☐	☐
22. Lost any teeth	☐	☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

YES	NO	(Please check Yes or No)
☐	☐	Has your present denture been relined? When _____
☐	☐	Is your present denture a problem? Describe _____
☐	☐	Satisfied with the appearance? _____
☐	☐	Satisfied with the comfort? _____
☐	☐	Satisfied with the chewing ability? _____
		When did you receive your first partial or complete denture? _____
		How long have you worn your present denture? _____

_____ _____

Patient or Guardian Signature Date

Staff Reviewed _____ Staff Entered _____

PATIENT NAME _____ DATE _____

Medical History

Name of Physician: _____

Most recent physical examination: _____ Purpose: _____

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

Do you require antibiotics before dental treatment? _____

Medical History and Information

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. Hospitalization for illness or injury ……	☐	☐
2. Allergic reaction to		
Aspirin, ibuprofen, acetaminophen…	☐	☐
Codeine……..	☐	☐
Erythromycin……..	☐	☐
Fluoride.....	☐	☐
Latex……..	☐	☐
Local anesthetic……	☐	☐
Metals (gold, stainless steel)…….....	☐	☐
Nuts……	☐	☐
Penicillin……	☐	☐
Sulfa……..	☐	☐
Tetracycline……..	☐	☐
Other medications _____.....	☐	☐
3. Anemia ……	☐	☐
4. Artificial Bones / Joints / Valves…….	☐	☐
5. Arthritis……	☐	☐
6. Asthma……...	☐	☐
7. Antidepressant medication……	☐	☐
8. Any lumps or swelling in the mouth…..	☐	☐
9. Cancer / Chemotherapy……...	☐	☐
10. Congenital Heart Defect……...	☐	☐
11. Contact lenses……..	☐	☐
12. Diabetes……	☐	☐
13. Difficulty Breathing……...	☐	☐
14. Drug / Alcohol Abuse……	☐	☐
15. Digestive disorders……	☐	☐
16. Epilepsy / Seizures / Fainting……	☐	☐
17. Emotional problems……	☐	☐
18. Emphysema……..	☐	☐
19. Fever Blisters / Herpes……	☐	☐
20. Glaucoma……...	☐	☐
21. Heart Murmur……	☐	☐
22. Heart Attack……	☐	☐
23. Heart Surgery / Pacemaker…….	☐	☐
24. Hemophilia / Abnormal Bleeding……	☐	☐
25. Hepatitis……	☐	☐

	YES	NO
26. High Blood Pressure……	☐	☐
27. High Cholesterol……...	☐	☐
28. Hives, skin rash, hay fever……	☐	☐
29. HIV Positive / AIDS……..	☐	☐
30. Head or neck injuries……..	☐	☐
31. Jaundice……	☐	☐
32. Kidney Problems……	☐	☐
33. Liver Disease……	☐	☐
34. Mitral Valve Prolapse……..	☐	☐
35. Psychiatric Problems……..	☐	☐
36. Prolonged Bleeding due to a slight cut.	☐	☐
37. Rheumatic Fever / Scarlet Fever……..	☐	☐
38. Radiation Therapy……..	☐	☐
39. Severe / Frequent Headaches……...	☐	☐
40. Shingles……	☐	☐
41. Sickle Cell Disease / Traits……	☐	☐
42. Sinus Problems……	☐	☐
43. Sexually Transmitted Diseases…….	☐	☐
44. Smoke or Chew Tobacco ……...	☐	☐
45. Tuberculosis……..	☐	☐
46. Tumor, abnormal growth……	☐	☐
47. Ulcers / Colitis……..	☐	☐
48. Other _____	☐	☐
ARE YOU:		
49. Aware of a change in your general health	☐	☐
50. Easily upset or irritated……	☐	☐
51. Presently being treated for any illness…..	☐	☐
52. FEMALE – Taking Birth control pills…….	☐	☐
53. FEMALE – Pregnant……	☐	☐
54. MALE – Prostate disorders……	☐	☐
Have you ever taken Medications for:		
55. Osteoporosis……..	☐	☐
56. Paget's disease of the Bone……..	☐	☐
57. Fibrous Dysplasia……..	☐	☐
58. Hypercalcaemia……..	☐	☐
59. Bone Metastases associated with Cancer	☐	☐
60. Have you ever taken Phen-Fen……..	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

_____

_____

List any medication, herbal supplements, and or vitamins taken with in the last two years _____

_____

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medial condition. **Please advise us in the future of any change in your medical history or any medications you may be taking.**

Payment for all treatment and services rendered are my responsibility.

_____ _____

Patient or Guardian Signature Date

Staff Reviewed _____ Staff Entered _____

PATIENT NAME _____ DATE _____

Financial Policy

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget. Dental treatment is an excellent investment in an individual's medical and psychological care.

OUR OFFICE AND YOUR INSURANCE PLAN – HOW THEY WORK TOGETHER

The staff is pleased that you have insurance benefits to help with the cost of your dental care. We would like to help you obtain the maximum use of these benefits. As a courtesy to our patients, we are happy to bill dental plans for dental services.

DO YOU ACCEPT MY INSURANCE? HOW MUCH WILL THEY PAY?

We currently accept all private care insurance plans (plans that do not require you to select a dentist from a list or require our office to accept a reduced fee for services). This means that we work with literally hundreds of companies. Although we can maintain computerized histories of payment by a given company, they do change; therefore it is impossible to give you a guaranteed quote at the time of service. We estimate your portion based on the most up-to-date information we have, but it is ONLY AN ESTIMATE.

I THOUGHT I PAID MY PORTION BUT I GOT A BILL. WHY?

We base the patient's portion of your bill on our most current data but there are many factors that can affect this estimate. There may be a deductible (individual or family) or you may have received treatment in another office prior to joining our office, which is not calculated into our database. Sometimes you may need to see a specialist for care, which also uses your annual benefit. Insurance companies do not (and cannot in most cases) notify us of changes to your benefits, they only notify you. If these situations apply to you, please let us know when we estimate your treatment plan so we may adjust accordingly.

INSURANCE DIDN'T PAY, NOW WHAT?

We bill your insurance as a courtesy. If insurance does not pay within 90 days, our office will request payment in full for services from you and let you collect the insurance funds that are due to you. We will provide you with any necessary claim information you may need. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not and can not be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

FINANCIAL OPTIONS

Our office does request payment in full for your portion at the time of service. You are personally responsible for payment of your account regardless of insurance coverage within 30 days from the date of services. We accept cash, checks, debit cards and major credit cards.

BROKEN APPOINTMENTS:

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hour** notice to avoid a **$50 cancellation fee** (emergencies are an exception).

If there is anything we can do to make your visit here more pleasant, please don't hesitate to ask one of our staff members.

In the event legal action should become necessary to collect any unpaid balance for services rendered to me or my family, I/we agree to pay reasonable attorney's fees or other such costs as the court determines proper. I agree that the venue for any legal action shall be Lewis County. I have read, understand, and accept the terms of the above outlined policies for insurance handling and financial commitments that I may incur as a result of treatment.

Patient _____ Patient/Guardian Signature

PATIENT NAME _____ DATE _____

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that may affect your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose you information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about appointments including voicemail messages, answering machines, and postcards.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

Please ask if you have any questions about your privacy rights or the protection of your health information.

ADDITIONAL 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 persons indicated below

ANY MEMBER OF MY IMMEDIATE FAMILY □ YES □ NO
SPOUSE ONLY □ YES □ NO
OTHER (Please Specify):_____ □ YES □ NO

_____ Signature of Patient/Guardian
Patient