PATIENT INFORMATION

DATE _____

NAME _____ ☐ MARRIED ☐ SINGLE ☐ MINOR ☐ MALE ☐ FEMALE
LAST FIRST M

SOCIAL SECURITY # _____

ADDRESS _____
STREET APT. # CITY STATE ZIP

BIRTHDATE _____ TELEPHONE _____
MONTH DAY YEAR HOME WORK CELL E-MAIL

NAME OF EMPLOYER _____ ADDRESS _____

IF FULL TIME STUDENT, SCHOOL NAME _____ GRADE _____

PERSON RESPONSIBLE FOR ACCOUNT - PLEASE CHECK ONE: ☐ PATIENT ☐ GUARDIAN ☐ SPOUSE ☐ FATHER ☐ MOTHER

INSURANCE INFORMATION

MINOR CHILD - MAY NEED TO COMPLETE BOTH BLOCKS FOR PARENT INFORMATION
ADULTS - COMPLETE PRIMARY INSURED
DUAL COVERAGE? ALSO COMPLETE SECONDARY INSURED

PRIMARY INSURED / IF NO INSURANCE COMPLETE FOR RESPONSIBLE PARTY	SECONDARY INSURED
LAST FIRST M	LAST FIRST M
STREET CITY STATE ZIP	STREET CITY STATE ZIP
HOME WORK CELL E-MAIL	HOME WORK CELL E-MAIL
BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT	BIRTHDATE (MO/DAY/YEAR) RELATIONSHIP TO PATIENT
EMPLOYER DENTAL INS. CO	EMPLOYER DENTAL INS. CO
SS# SUBSCRIBER # GROUP #	SS# SUBSCRIBER # GROUP #

PERSON TO CONTACT IN CASE OF EMERGENCY

Name _____

Address _____

City/State/ZIP _____

Telephone # _____

AUTHORIZATION

I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payors and/or other health professionals by any method, including electronic transfer.

X _____
Patient or Responsible Party

_____
Date State Driver's License #

Has any member of your family ever been treated in our office?
☐ Yes ☐ No

Whom may we thank for referring you to our office?

_____

METHOD OF PAYMENT

Responsible party currently has an account with this office
☐ Yes ☐ No

☐ Payment in full at each appointment (cash or personal check)

☐ Payment in full at each appointment (☐ VISA ☐ MC ☐ OTHER)

Card # _____ Exp. Date _____

☐ I wish to discuss the Dental Office's Financial Policy

SERVICE CHARGE

If I do not pay the entire new balance within _____ days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of _____% per month (or a minimum charge of $_____ for a balance under $_____) which is an annual percentage rate of _____% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Welcome to our office!

Patient Name _____ **Date** _____

Do you have any specific concerns about your teeth today? Describe: _____

When was your last visit to a dentist? _____ With Dr. _____

Do you ever have clicking, popping, or discomfort in your jaw joint? Describe: _____

Do your gums ever bleed? Yes____ No____

Does food catch between your teeth? Yes____ No____

Do you clench or grind your teeth? Yes____ No____

Do you smoke or chew tobacco? Yes____ No____

Are you interested in straightening your teeth? Yes____ No____

Are you interested in whiter teeth? Yes____ No____

Are you under a physician's care now?

Why? _____

Who? _____

Physician's Phone _____

Have you ever been hospitalized or had a major operation? Explain: _____

_____

Please list any medications you are taking right now:

_____

_____

_____

_____

_____

_____

_____

Please check if you have or have had any of the following:

- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Irregular Heart Beat
- ☐ Angina/ Chest Pain
- ☐ Heart Attack/ Failure
- ☐ Congenital heart Disorder
- ☐ Heart Pacemaker
- ☐ Heart Surgery
- ☐ Stroke
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Liver Disease
- ☐ Kidney Problems
- ☐ Cortisone Medicine
- ☐ Artificial Joint
- ☐ Anemia
- ☐ High Cholesterol
- ☐ Hemophilia
- ☐ Leukemia
- ☐ Recent Blood Transfusion
- ☐ Asthma
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Drug/ Alcohol Addiction
- ☐ Tuberculosis
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ HIV Positive
- ☐ AIDS
- ☐ Herpes
- ☐ Cold Sores

Women (please check): ☐ Pregnant/Trying to get pregnant ☐ Nursing ☐ Taking oral contraceptives

Are you allergic to any medications or substances listed below?

- ☐ Aspirin
- ☐ Penicillin
- ☐ Codeine
- ☐ Metal
- ☐ Latex Rubber
- ☐ Acrylic
- ☐ Other (please list): _____

Nitrous Oxide gas $75.00 per visit, Yes___No___

To the best of my knowledge, all of the preceding questions are answered correctly. If any changes in my health status or if any of my medications change, I will inform Dr. James To, D.M.D. and his staff at my next appointment.

X_____

Patient Signature (Parent or Guardian)

X_____

Reviewed by Doctor

Shelby Dental
James To, DMD

3501 Shelby Rd Suite A Lynnwood, WA 98087 Phone 425-743-2999

Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the office of Dr James To, DMD. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office healthcare operations. The statement of Privacy Practices also describes my rights as and the responsibilities and duties of this office with respect to my protected health information. the statement of Privacy Practices is also posted within this facility.

Dr. James To, DMD reserves the right to change the privacy practices that are described in the statement of privacy Practices. if Privacy Practices change, I will be offered a copy of the revised Statement at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practiced by requesting that one be mailed to me.

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

_____
Name of Patient or Personal Representative

_____
Signature of Patient or Personal Representative

_____
Date

_____
Description of Personal Representative's Authority

OFFICE USE BELOW THIS LINE
Record of Acknowledgement not obtained

Provided prior treatment? ____YES ___ NO

Date Provided: _____

Reason for Denial:
____ Needed more time to review Statement of privacy Practices
____ Wanted to consult with another person, before signing
____ Reason not given
____ Other (Explain) _____

SHELBY FAMILY DENTAL FINANCIAL POLICIES

PAYMENT:

Payment is Due at the time services are rendered. For uninsured patients a 5% discount is offered for treatment paid in full on the day of service.
We accept: CASH, CHECK, MONEY ORDER, VISA, MASTER CARD, DISCOVER, AMERICAN EXPRESS and CARECREDIT.

DENTAL INSURANCE:

As a courtesy to our patients we will bill your insurance company for you. It is important for you to be informed that our professional services are rendered to you, and charged to you. In the event your insurance company does not pay for these services, you are financially responsible for all charges.
For this reason, PLEASE get to know your insurance plan. We accept dozens of plans, all with DIFFERENT AND CHANGING RULES. Learning your plan's rules will save you hassles and possibly dollars.

BILLING POLICY:

When necessary statements are mailed for outstanding balances. Interest charges will accrue on accounts 60 days overdue at 1.5% per month.
There is a $35.00 charge for all NSF checks.

APPOINTMENT SCHEDULING:

We will try to arrange convenient appointment times for you, however some procedures are only done on certain days at specific times of that day.
Your appointment time is RESERVED JUST FOR YOU, for this reason Dr. To requires advance notice of 48 hours if you are unable to keep your appointment. This allows staff ample time to offer your appointment to another patient in need.
Please be sure to keep your contact information current with this office, so your appointment can always be confirmed.
Dr. To does charge a $75.00 fee for failed appointments.

AGREEMENT:

As a patient or legal guardian of a minor patient. I agree to pay for all services rendered. In the event legal action should become necessary to enforce payment of any charges, I agree to be responsible for and pay all reasonable legal costs incurred.

AUTHORIZATION:

I hereby authorize Shelby Family Dental (James To, D.M.D.) to release my information regarding dental history and treatment for the purpose of validating and determining benefits payable in connection with each dental insurance claim.
I authorize payment directly to Shelby Family Dental (James To, D.M.D.)
and the group insurance benefits otherwise payable to me.

Please Print Patient's Name: _____

Signature of Patient or Legal Guardian: _____ Date: _____