MOUNTAIN VIEW DENTAL

PATIENT INFORMATION AND HEALTH HISTORY

Date: _____ Name *(First and Last)*: _____ Middle Initial: _____

Nickname/Preferred Name: _____ SSN: _____-_____-_____ DL #: _____

Home Phone: (_____)_____ Cell: (_____)_____ EMAIL: _____

Street Address: _____ City: _____ State: ___ Zip: _____

Mailing Address if different from above:

Street Address: _____ City: _____ State: ___ Zip: _____

Date of Birth: _____ Sex: ☐ M ☐ F Occupation/Employer: _____

Preferred Pharmacy: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

Who referred you to our office (or how did you hear about us)? _____

Bonus Question: Tell us a fun fact about you: _____

Insurance Information

Primary Dental Insurance: _____ Subscriber ID: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____

Secondary Dental Insurance: _____ Subscriber ID: _____

Subscriber's Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____

Dental Information

Yes	No	Unknown	
□	□	□	Do your gums bleed when you brush?
□	□	□	Have you ever had orthodontic treatment
□	□	□	Are your teeth sensitive to cold, hot, sweets or pressure?
□	□	□	Do you have headaches, earaches or neck pain?
□	□	□	Have you been told you have periodontal (gum) disease?
□	□	□	Do you wear removable/fixed dental appliances?
□	□	□	Are you aware of loose teeth or broken fillings?
□	□	□	Are your gums swollen or tender?
□	□	□	Are you a mouth breather?
□	□	□	Do you frequently get blisters on lips or mouth?
□	□	□	Do you ever get a burning sensation on tongue?
□	□	□	Do you chew on one side of your mouth?
□	□	□	Do you experience clicking/popping in your jaw?
□	□	□	Do you get jaw pain or fatigue?
□	□	□	Does food collect between your teeth?
□	□	□	Do you have pain when brushing?
□	□	□	Do you or have you been told you grind your teeth?

Have you had any problems associated with previous dental treatment or past dental experiences?

□ Yes □ No If yes, explain:

Oral Habits (*Check all that apply*)

□ Tongue/lip piercing
□ Using teeth as a tool
□ Bite nails or other objects
□ Musical instruments with mouthpiece

Which fluoride products do you use/consume?

□ Toothpaste □ Water □ Rinses □ None □ Other_____

What is most important to you at the dental office?

How do you feel about the appearance of your teeth?

How often do you clean between your teeth? _____/day
How often do you brush? _____/day
How often do you have dental check ups? _____

Please indicate the level of dental care you would like us to provide:

□ Emergency care as needed
□ Consultation to solve a specific problem
□ Routine exam and preventive care
□ Comprehensive care, optimal dental health and appearance

Medical Information

Physician(s): _____ Phone: (_____)_____

Name of Clinic: _____ City: _____

Yes	No	Unknown	
□	□	□	Are you in good health?
□	□	□	Have there been any changes in your health within the past year?
□	□	□	Are you under the care of a physician? If so, what are the conditions being treated? _____
□	□	□	Have you had any serious illness, operation or been hospitalized in the past 5 years? If so, what was the illness or health concern? _____
□	□	□	Do you consume snacks/beverages containing sugar between meals?
□	□	□	Do you snore?
□	□	□	Do you wake up feeling refreshed?
□	□	□	Have you ever been told you have sleep apnea?
□	□	□	Have you ever worn a CPAP? If yes, do/did you use it regularly? Explain: _____

What is your alcohol consumption history?

□ None, I don't drink at all
□ Light drinker: Consumed less than 3 drinks per week on average
□ Moderate drinker: Consumed 3 to 14 drinks per week on average in past year
□ Heavy drinker: Consumed 2 to 3 drinks per day on average in past year

What is your history of tobacco use?

□ Never smoked
□ Former smoker, Age Began: _____ Year Quit: _____

Recreational Drug Use

□ NONE
□ Marijuana; what method (*smoke, edibles, etc*): _____
□ Other: _____

Smokeless tobacco use

□ Never used smokeless tobacco
□ Current tobacco chewer
□ Former tobacco chewer, Year Quit: _____
□ Current vape user
□ Former vape user

Are you taking any medications (Prescription or Over-the-Counter)?

Name of Drug	Purpose

Are you allergic to or have you had a reaction to:

Yes	No	Unknown	
□	□	□	Local anesthetics
□	□	□	Penicillin or other antibiotics
□	□	□	Barbiturates, sedatives or sleeping pills
□	□	□	Sulfa drugs
□	□	□	Codeine or other narcotics
□	□	□	Latex
□	□	□	Iodine
□	□	□	Hay fever/seasonal
□	□	□	Metal

Please list any drugs or medicines that you cannot or prefer to not take because of allergies or side-effects, especially antibiotics for infections, analgesics for pain, and anesthetics: _____

What is your preferred drug for mild and/or severe pain? _____

What is your preferred antibiotic for an infection? _____

List any street/recreational drugs you use: _____

PLEASE (X) A RESPONSE TO INDICATE IF YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING DISEASES OR PROBLEMS

Yes	No	Unknown		Yes	No	Unknown	
□	□	□	Abnormal Bleeding Controlled? (*circle one*) Good Fair Poor	□	□	□	Disease, drug or Radiation-induced immunosuppression
□	□	□	AIDS or HIV	□	□	□	Mental Health disorder
□	□	□	Anemia	□	□	□	Night sweats/Menopausal
□	□	□	Herpes	□	□	□	Neurological disorders
□	□	□	Arthritis	□	□	□	Osteoporosis
□	□	□	Rheumatoid Arthritis	□	□	□	Persistent swollen glands
□	□	□	Asthma	□	□	□	Respiratory problems If yes, please specify: _____
□	□	□	Blood Transfusion If yes, date: _____	□	□	□	Severe headaches/migraines
□	□	□	Cancer/Chemotherapy/Radiation	□	□	□	Sexually transmitted disease
□	□	□	Cardiovascular Diseases? □ Angina Pectoris □ Heart Murmur □ Bypass Surgery □ Mitral Valve Prolapse □ Pacemaker □ Rheumatic Fever □ Artificial Valves □ Stents □ Heart Attack Date: _____	□	□	□	Sinus trouble
				□	□	□	Sores or ulcers in the mouth
				□	□	□	Stroke If yes, date: _____
				□	□	□	Systemic Lupus Erythematosus
				□	□	□	Tuberculosis
□	□	□	Chest Pain/Shortness of breath upon exertion	□	□	□	Thyroid problems
□	□	□	Chronic Pain	□	□	□	Ulcers
□	□	□	GE Reflux, persistent heartburn, or GI Disease	□	□	□	Excessive urination/thirst
□	□	□	Hemophilia	□	□	□	Have you ever been told you needed to pre-medicate for dental treatment?
□	□	□	Hepatitis, Jaundice or Liver Disease				
□	□	□	High/Low Blood Pressure	□	□	□	Are you pregnant?
□	□	□	Recurrent Infection If yes, what type of infection? _____	□	□	□	Are you planning to be pregnant?
□	□	□	Diabetes				
□	□	□	Epilepsy				
□	□	□	Fainting Spells or Seizures				
□	□	□	Dry Mouth				
□	□	□	Joint Replacement				
□	□	□	Eating Disorder If yes, please specify: _____				

Do you have any disease not listed above that you think we should know about?

Please feel free to add any additional information you would like us to know about your medical or dental care:

I certify that I have read and understand the above. 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 staff responsible for any action they take because of errors or omission that I may have made in the completion of this form.

_____ _____

Signature of Patient/Legal Guardian Date

I HAVE REVIEWED THE ATTACHED MEDICAL/DENTAL HISTORY AND HAVE NOTED ANY CHANGES

Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist
Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist
Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist
Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist
Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist
Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist
Date	Comments/Changes
Signature of patient (or guardian)	Signature of Dentist/Hygienist

Payment for your dental care

We believe in partnering with our patients to discover options that allow you to achieve the level of dental care you desire. Our guidelines below provide information on how we can best assist you in your decisions.

PAYMENT OPTIONS

Payment is due at the time of service. You can choose to pay with cash, check, credit/debit or HSA/FSA.

All treatment recommendations made in this practice are based solely on your clinical needs and your wishes. We encourage you to consider that exceptional dental care as an investment that will continue to your overall health for many years to come. If you have any questions about how we can help you make that investment, please let us know.

Payment over time of treatment. If your treatment requires a major investment or multiple appointments over an extended time, we can set up a simple payment structure that allows you to spread out the fee in installments starting with your initial approval of treatment and ending with your final visit for that treatment.

If you wish to explore ways to extend payments beyond the time of scheduled treatment, we can help you understand your options for financing your care when needed.

IF YOU HAVE DENTAL BENEFITS

To the best of our ability, we will assist in understanding and maximizing your benefits. As a courtesy, we prepare and electronically submit all necessary forms to your dental benefit administrator. Our estimate of your out-of-pocket costs will take those benefits into consideration. **Please remember, we cannot guarantee the amount of your benefit and there may be a remaining balance that you are responsible for.** Balances remaining after 90 days will be the patient's responsibility to pay.

RESERVATION & CANCELLATION:

When you book your appointment, we reserve time specifically for you and your scheduled procedure. If you are unable to make your appointment, we request that you notify our office at least **48 hours notice** prior to your reserved appointment time. Missed appointments (no-shows) or cancellations under 48 hours may result in a $50 charge and we may ask for a deposit before booking your next appointment.

AUTHORIZATION AND RELEASE

I authorize Mountain View Dental to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers. I authorize and request my insurance company to pay directly to the dentist or dental office the insurance benefits otherwise payable to me. I understand that my dental insurance company may pay less than the actual bill for services. I **agree to be responsible for payment for all services rendered on my behalf or my dependents**. If I do not pay the entire balance on my account within 90 days from the date of service, a finance charge of 1.5% on the balance then unpaid and owed will be assessed each month thereafter. I realize that failure to keep my account current may result in Dr. Joshua Kirk being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional service. In the case of default on payment of my account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances. I further understand that if collection action is taken on my account and court action is necessary, the venue will be in Kittitas County.

By my signature below, I understand and agree to the above conditions, authorization and release.

Patient Signature (or Parent/Guardian)	PRINT Name	Date

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Mountain View Dental Center. 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 health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Mountain View Dental Center reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number:	**Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

CREDIT CARD
AUTHORIZATION

Patient Name_____

I authorize Mountain View Dental to use the payment method listed below for the estimated patient portion above what my dental benefits cover. I acknowledge that any balance remaining after 90 days or not paid by my dental benefits carrier will be my responsibility to pay.

_____ _____

Patient, Parent, or Guardian Signature Date

Cardholder Information

Name: _____

Billing Address: _____

City: _____ State: _____ Postal Code: _____

Email: _____

Phone Number: _____ Best Time to Call? _____

Credit Card Information

Credit Card Type: ☐ VISA ☐ Master Card ☐ AMEX ☐ Discover ☐ HSA

Card Number: _____

Expiration Date: _____/_____ Security Code: _____

Cardholder Signature:_____

Financing (if applicable)

I authorize Mountain View Dental to charge my credit card $_____

☐ One Time ☐ Weekly ☐ Every Other Week ☐ Monthly

On Specified Dates: _____

Duration: _____ months

First Payment Date: _____ Last Payment Date: _____

_____ _____

Patient, Parent, or Guardian Signature Date

Mountain View Dental
(509) 962-2755 PHONE
(509) 962-2750 FAX
info@ellensburgdentist.com

AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

Patient Date of Birth: _____/_____/_____

I authorize: _____

_____

_____

to release dental records; x-rays and treatment needs for the purpose of further dental treatment to:

Mountain View Dental
708 E. Mountain View Ave
Ellensburg, WA 98926

_____ _____/_____/_____
Patient (or Guardian) Signature Date