Patient Information Form

Name: _____ Birthdate: _____

Mailing Address: _____ Phone: _____

City: _____ Zip: _____ Social Security: _____

Email: _____ May we text / email you? [ ] yes [ ] no

Phone Carrier for texts: T-Mobile Verizon Sprint AT&T Other _____

Employer: _____ Phone: _____

Address: _____ City: _____ Zip: _____

Person Responsible for Bill: _____ Relation: _____

Parent/ Spouse: _____ Phone: _____

Who may we contact in case of an Emergency? _____ Phone: _____

Who may we thank for referring you/ how did you hear about us? _____

Previous Dentist: _____ Last treated: _____

City: _____ Phone: _____ X-rays within 3 years? [ ] Yes [ ] No

Physician: _____ Phone: _____

Location: _____ Last treated: _____

Insurance Information

Dental Insurance Name: _____ Member ID/ S.S. #: _____

Subscriber name: _____ Birthdate: _____ Group #:_____

Other Dental insurance: _____ Member ID/ S.S. #: _____

Subscriber name: _____ Birthdate: _____ Group #: _____

Medical Insurance Name: _____ Member ID: _____

Subscriber name: _____ Birthdate: _____

Address: _____ City: _____

State: _____ Zip: _____ Phone: _____

Patient Health History

Current Medications: _____

_____

Allergies to Medications: _____

Any other Allergies: _____

Any medical problems/ conditions/ special concerns you may have? _____

_____

Any recent surgeries: _____

Do you need to be on pre-med? [ ] YES [ ] NO If yes, what type? _____

Indicate, with an X in either box, any conditions that apply to you or has applied to you:

YES	NO	YES	NO	YES	NO
[ ]	[ ] Hepatitis	[ ]	[ ] Tuberculosis	[ ]	[ ] Fainting
[ ]	[ ] Heart Troubles	[ ]	[ ] Anemia	[ ]	[ ] Dizziness
[ ]	[ ] Hypertension	[ ]	[ ] Prolonged Bleeding	[ ]	[ ] Ulcers
[ ]	[ ] Rheumatic Fever	[ ]	[ ] Kidney Trouble	[ ]	[ ] Stroke
[ ]	[ ] Epilepsy	[ ]	[ ] Thyroid Condition	[ ]	[ ] HIV/ AIDS
[ ]	[ ] Diabetes	[ ]	[ ] Arthritis	[ ]	[ ] Colitis
[ ]	[ ] Asthma	[ ]	[ ] Pregnant now/ trying to get pregnant? Due: _____		
[ ]	[ ] Use a C-Pap	[ ]	[ ] Sleep Apnea		

Patient Questionnaire:

1. What brings you in today?
   _____
2. What can we do to make your appointment more comfortable?
   _____
3. What is your current oral hygiene routine?
   _____
   _____
4. Do you have any dental concerns, questions, fears?_____
   _____

On a level from 1 to 10, how anxious are you about being at the dentist? _____

On a level from 1 to 10, how is your dental health? _____

INFORMATION ON INSURANCE POLICIES AND PROCEDURES

In order to keeps fees down, we require your co-payment *(the amount not covered by your insurance)* to be paid at the time of service. If you are unsure of your co-payment, 30% will be required until your co-payment can be verified; 50% for prosthetics. If you desire, you may pay the balance owing at the time of service and be reimbursed by your insurance company, if applicable.

As a courtesy, our office will bill your insurance company directly. Our office will not be held responsible for non-payment of fees from your carrier for any reason or for the delay of payment on insurance claims. If, for any reason, the payment is delayed 60 days or more, you will need to deal with your carrier directly.

Please note that the estimates of charges and insurance coverage are subject to change. We will do our best to keep you updated if and when changes do occur. Please contact us with any new information you may have that would affect billing.

CANCELLATION AND BROKEN APPOINTMENT POLICY

We require a minimum of 24 business hours' notice to cancel an appointment. Less than 24 hours will result in a $75.00 rescheduling fee. Please remember that your appointment time has been set aside especially for you, so please choose carefully.

BILLING INFORMATION

If you have no insurance, you are required to pay the balance in full at the time of service, unless arrangements are made prior to your appointment. There is a re-billing fee of 1.5% per month (18% annually) for accounts over 30 days past due. *(Minimum monthly charge is $1.00)* VISA and Mastercard are always welcome.

I understand and agree that I am ultimately responsible for the balance of my account. I have read and understand the information given and have asked all questions that I may have when reading this for.

Signed: _____ Date: _____

Patient or Guardian (if under 18)

Thank you.

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

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 our record to others unless you direct us to do so or unless the law authorities place a request. Please contact the front desk receptionist to make that request at 425-353-5854.

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

My signature below acknowledges I was offered a copy of the Notice of Privacy Practices.

Patient or Legally Authorized Individual Signature **Date**

This form will be retained in your records.

Confidential Communications Request

This form will give us, Heidi Johnson D.D.S. Dental Office, permission to share information with those you have listed below.

Name Relation

_____ _____

_____ _____

_____ _____

Please check what is allowed for us to share in regard to patient information

____ appointment times

____ financial (insurance, payments)

____ treatment, medical details

Date _____ Patient Name _____

Signature _____

Self _____ Guardian _____

Heidi Johnson D.D.S.
2121 Madison Street Ste. A
Everett, WA 98203
425-353-5854

X-ray and Records Release Form

I, _____, am requesting my dental records and x-rays to be released to:

- ☐ Heidi Johnson D.D.S.
- ☐ Myself
- ☐ Other: _____

Fax: 425-355-7426

Email: office@madisonstreetdentalclinic.com

Mail: Address above

Signature_____

Date_____