ROOSEVELT DENTAL CENTER
OF SKAGIT COUNTY

Keeping our community smiling

Patient Name:_____

Birthdate:_____Mailing Address:_____

How did you hear about our office: _____

Name & relationship of those we may discuss your treatment and account with:_____

_____

Dental Health History

Are you nervous about dental treatment?	Y ☐	N ☐
Have you ever had any complications with anesthetic or prior dental treatment?	Y ☐	N ☐
Are you unhappy with the appearance of your teeth?	Y ☐	N ☐
Would you like your teeth to be whiter?	Y ☐	N ☐

Medical Health History

Physician Name:_____Phone:_____

Emergency Contact Name: _____Phone:_____

Do you have allergies to any medications, latex, foods, dyes?	Y ☐	N ☐
If yes, please describe:_____		
Are you taking any medications or supplements?	Y ☐	N ☐
If yes, please describe:_____		
Have you ever taken any bisphosphonate drugs (usually for osteoporosis or osteopenia)?	Y ☐	N ☐
Do you now or have you ever used tobacco or nicotine based products, marijuana, vaping, e-cigarettes?	Y ☐	N ☐
If yes, please describe:_____		
Do you now or have you ever used recreational drugs?	Y ☐	N ☐
If yes, please describe:_____		

Do you have any of the following conditions?

Y	N		Y	N		Y	N	
☐	☐	High blood pressure	☐	☐	Diabetes: type I/II/gestational	☐	☐	ADD/ADHD
☐	☐	Heart disease	☐	☐	Lung/breathing problems	☐	☐	Hepatitis
☐	☐	Chest pains/angina pectoris	☐	☐	Asthma	☐	☐	HIV/AIDS
☐	☐	History of heart attack or stroke	☐	☐	Seasonal allergies	☐	☐	Tuberculosis
☐	☐	Heart surgery	☐	☐	Sleep apnea	☐	☐	Bleeding disorder
☐	☐	Heart valve replacement	☐	☐	Snoring	☐	☐	Acid reflux
☐	☐	Prosthetic cardiac device	☐	☐	Thyroid disorder	☐	☐	Anxiety/Depression
☐	☐	Rheumatic heart disease	☐	☐	Headaches/Migraines	☐	☐	Cancer treatment
☐	☐	Organ transplant	☐	☐	Epilepsy/Seizures	☐	☐	Current pregnancy
☐	☐	Joint replacement	☐	☐	Memory problems	☐	☐	Autoimmune disease
☐	☐	High cholesterol						

Do you have any other illness, condition, or problem not listed above? Y ☐ N ☐

If yes, please describe:_____

Patient/Guardian Signature:_____ Date:_____

Dr. Signature:_____Date:_____BP/Staff Initials:_____

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Acknowledgement and Consent

Health history

I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the health history questionnaire fully and accurately to the best of my ability.

Release of information

I understand that the dentist may need to collaborate with other healthcare providers and/or third-party payors in order to provide the best standard of care for me. I authorize the dentist to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of dental care to third-party payors and/or other health care providers related to my care.

Financial policies

I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not the dental office's responsibility.

I understand that I am expected to pay what is due for my treatment when I receive it. I understand that when a child of divorced parents is seen, whichever parent accompanies the child to their visit will be expected to pay. I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement from the dental office for this, and I am expected to pay in full within 15 days of receiving this statement. A late fee of 18% of total balance or $25.00 (whichever is greater) will be applied to balances over 30 days.

I agree to be responsible for timely payment for all services rendered on my behalf and on behalf of my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policy.

I understand that if my account remains unpaid, it may be transferred to a collections agency. If legal action is commenced, the venue will be placed in Skagit County, WA.

I understand that my account will be charged a $50 fee for any dishonored check, and that I am expected to pick up the check and pay the balance and subsequent fees in cash.

I understand that these policies may be superceded by a written and signed agreement of an alternate policy specific to my account.

Rescheduling/cancellation policies

I understand that if I need to reschedule an appointment, or cannot make an appointment, I must give 48 hours notice to a staff member. If I do not give adequate notice, my account may be charged a $55 cancellation fee.

I understand that if I fail or cancel more than three appointments without appropriate notice, my active patient status will be reduced to emergency status, and I will be advised to seek an alternate dental provider outside of the office.

Privacy Practices

I acknowledge receipt of Statement of Privacy Practices.

_____

Signature of patient (or parent/guardian if a minor) *date*

_____

Printed Name of patient (or parent/guardian if a minor) *Patient Name (if minor)*

Preferred method of contact for appointment reminder.

☐ Phone _____ ☐ Text _____ ☐ e-mail _____

1210 Roosevelt Avenue • Mount Vernon, WA 98273 • 360.424.5650

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Patient Information:

Name:_____

Preferred Name:_____

Address:_____

_____

Phone: _____

Mobile Phone: _____

Employer:_____

Birth Date:_____ #

Email:_____Pr

Previous DDS:_____

Last Seen: _____

Insurance Information Primary:

Ins. Co: _____

Ins. Co Phone #:_____

ID/Member #:_____

Group #: _____

Subscriber: _____

Subscriber Info if not Patient Primary:

Name: _____

DOB: _____

Insurance Information Secondary (if applicable):

Ins. Co:_____

Ins. Co Phone #:_____

ID/Member #:_____

Group #:_____

Subscriber:_____

Subscriber Info if not Patient Secondary: (if applicable)

Name: _____

DOB: _____

Patient Signature:_____ **Date:**_____

(Parent/Guardian if a minor)