WASHOUGAL
FAMILY DENTAL

Adult Health History

Although dentists primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the care, that you will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Patient Information

Today's Date:

Name:

○ Male ○ Female

Birth date:

Age:

Social Security Number:

Drivers License Number:

Home Address:

E-mail:

Home Number:

Cell Number:

Work Number:

Employer:

Occupation:

Whom may we thank for referring you?

Previous Dentist and last visit date:

Spouse Information

His/Her Name:

Employer:

Birth Date:

Social Security Number:

Drivers License Number

Work Number:

Dental Insurance

Primary Dental Insurance:

Insurance Company Name:

Insurance Company Address:

Insurance Company Phone Number:

Group Number (Plan, Local or Policy Number):

Insured's Name:

Relation:

Insured's Birth Date:

Insured's ID Number:

Insured's Employer:

Secondary Dental Insurance:

Insurance Company Name:

Insurance Company Address:

Insurance Company Phone Number:

Group Number (Plan, Local or Policy Number):

Insured's Name:

Relation:

Insured's Birth Date:

Insured's ID Number:

Insured's Employer:

Medical History

Do you have a Physician?

◯ Yes ◯ No

Physician's Name:

Phone Number:

Are you currently under the care of a Physician?

◯ Yes ◯ No

Please explain:

In the event of an emergency, whom may we contact?

Relation:

Contact Number:

Your current physical health is:

☐ Good ☐ Fair ☐ Poor

Do you use tobacco?

◯ Yes ◯ No

How much a day?

Are you taking any medications or supplements?

◯ Yes ◯ No

Please list each one:

Have you taken Fosamax or any Bisphosphonate?

◯ Yes ◯ No

Have you ever taken Phen-fen:

◯ Yes ◯ No

Have you ever had any of the following diseases or medical problems/conditions?

Abnormal Bleeding	◯ Yes	◯ No	Hepatitis	◯ Yes	◯ No
Alcohol/Drug Abuse	◯ Yes	◯ No	Herpes/Fever Blisters	◯ Yes	◯ No
Anemia	◯ Yes	◯ No	High Blood Pressure	◯ Yes	◯ No
Arthritis	◯ Yes	◯ No	HIV+/AIDS	◯ Yes	◯ No
Artificial joints/valves	◯ Yes	◯ No	Kidney Problems	◯ Yes	◯ No
Asthma	◯ Yes	◯ No	Liver Disease	◯ Yes	◯ No
Blood Transfusion	◯ Yes	◯ No	Low Blood Pressure	◯ Yes	◯ No
Cancer/Chemo	◯ Yes	◯ No	Mitral Valve Prolapse	◯ Yes	◯ No
Colitis	◯ Yes	◯ No	Pacemaker	◯ Yes	◯ No
Cong. Heart Defect	◯ Yes	◯ No	Psychiatric Problems	◯ Yes	◯ No
Diabetes	◯ Yes	◯ No	Radiation Treatment	◯ Yes	◯ No
Difficulty Breathing	◯ Yes	◯ No	Rheumatic Fever	◯ Yes	◯ No
Emphysema	◯ Yes	◯ No	Seizures	◯ Yes	◯ No
Epilepsy	◯ Yes	◯ No	Shingles	◯ Yes	◯ No
Fainting Spells	◯ Yes	◯ No	Sickle Cell Anemia	◯ Yes	◯ No
Frequent Headaches	◯ Yes	◯ No	Sinus Problems	◯ Yes	◯ No
Glaucoma	◯ Yes	◯ No	Stroke	◯ Yes	◯ No
Hay Fever	◯ Yes	◯ No	Thyroid Problems	◯ Yes	◯ No
Heart Attack	◯ Yes	◯ No	Tuberculosis (TB)	◯ Yes	◯ No
Heart Murmur	◯ Yes	◯ No	Ulcers	◯ Yes	◯ No
Heart Surgery	◯ Yes	◯ No	Venereal Disease	◯ Yes	◯ No
Hemophilia	◯ Yes	◯ No			

Have you been hospitalized for any reason?

◯ Yes ◯ No

If so, please explain:

Please list any medical conditions that you have ever had:

Are you allergic to any of the following?

Aspirin	◯ Yes	◯ No	Latex	◯ Yes	◯ No
Codeine	◯ Yes	◯ No	Penicillin	◯ Yes	◯ No
Dental Anesthetics	◯ Yes	◯ No	Tetracycline	◯ Yes	◯ No
Erythromycin	◯ Yes	◯ No	Sulfa	◯ Yes	◯ No
Jewelry/Metals	◯ Yes	◯ No			

Please list any other medications or materials that you are allergic to:

For Women Only:

Are you pregnant or any chance that you could be pregnant?

◯ Yes ◯ No

Are you nursing?

◯ Yes ◯ No

If you are using Oral Contraceptives, it is important that you understand that antibiotics, and other medications, may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the use of antibiotics or other medications. Please consult with your physician for further guidance.

Dental History

Why have you come to the Dentist today?

Your current dental health is?

☐ Good ☐ Fair ☐ Poor

Are you currently in pain?

◯ Yes ◯ No

Have you ever had difficulties with dental treatment?

◯ Yes ◯ No

Have you ever had pain with your jaw joint? (TMJ)

◯ Yes ◯ No

Are you happy with your smile?

◯ Yes ◯ No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if there has been a change in my health.

My signature indicates that I understand the information as outlined and any questions I have with regard to above information have been answered.

Name:

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General Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs or any other diagnostic aids he/she deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor employ any such assistance as he/she deems appropriate.

Drugs and Medications
I understand that antibiotics and analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).

Crowns, Bridges, Onlays
I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they are kept on until the permanent crowns are delivered. I realize final opportunity to make changes in my new crown, bridge, or onlay (including shape,fit, size, and color) will be before cementation.

Complete and Partial Dentures
I realize that complete or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness, and possible breakage. I realize final opportunity to make changes to my dentures (including shape, t, size, and color) will be at the “teeth in wax” try in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.

I understand that dentistry is not an exact science, therefore, practitioners cannot fully guarantee the outcome of treatment. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment that I have authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction and alternatives have been discussed.

My signature indicates that I understand the information as outlined and any questions I have with regard to above information have been answered.

Name:

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Office Policies

EXPECTED PAYMENT
To keep our fees to you as low as possible, we ask that payment be made at the time of service. For your convenience an estimate for services will be prepared in advance of your appointment/s to ensure you opportunity to plan for your dental care. We believe whether you privately pay or have dental insurance to assist you, everyone deserves the care they need and want.

DENTAL INSURANCE
We are happy to file your dental claims to assist you in receiving the full benefits of your coverage. We request that you familiarize yourself with your insurance benefits and provide us the correct information to assist you with the submittal of claims. We will accept the estimated insurance payment directly from your insurance company provided payment is received from them within 45-60 days. Please realize that your insurance is a contract between you, your employer, and the insurance company; therefore we cannot guarantee coverage and your assistance may be requested. Not all services are covered benefits in all contracts; therefore, you are ultimately responsible for the total amount of your dental fees. The treatment recommended for you is indicated regardless of your dental insurance benefits, deductible's, limitations, or maximums.

I hereby authorize payment directly to the dental office of the insurance benefits otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment. I grant the right to Washougal Family Dental/Dr. Justin L Cochell to release dental histories and other information about my dental treatment to third party payers.

PAYMENT OPTIONS
For your convenience we provide a variety of payment options to help you receive the quality care you need to enjoy a healthy and confident smile. Please identify which form of payment is most convenient for you at the time of service. PLEASE NOTE: A $25.00 NSF fee will be charged for all returned checks. Should you desire a monthly payment plan we invite you to complete a simple finance company application. There are no application fees or a down payment and the loan can be interest-free.

PAST DUE BALANCES
If applicable balances owing from a prior visit where insurance is not pending, or an insurance payment has not been received within 90-days, or the account has been sent to collections is considered past due. Payment of any past due balance is required to be paid in full before incurring new charges. Balances over 90-days may be subject to a re-billing fee.

CANCELLATIONS
If you are unable to keep your reserved appointment we request a 48-hour courtesy notice. Early notification ensures that we can offer you a more convenient appointment and allows us sufficient time to accommodate the needs of another patient. A missed appointment fee of $50.00 will be charged when advanced notice is not provided. We realize that emergencies do occur and we will be flexible under those circumstances. Please be advised that (3) missed appointments without the requested notice within a 12-month period may result in dismissal from our practice.

INFORMATION CHANGES
To ensure your records are current please notify us of any changes related to medical history, telephone number/s, address, employer or insurance information as they occur.

HIPAA
I understand that, under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have certain rights to privacy regarding my protected health information.

I understand that this information can and will be used to:
- Conduct, plan and direct my treatment and follow up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Washougal Family Dental at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

My signature indicates that I understand the information as outlined and any questions I have with regard to above information have been answered.

Name: