

Are You A Candidate For Cosmetic Dentistry?

Why change your smile? Don't if you are happy with it, but ask yourself the following questions:

Name (please print)

Date

- | | | |
|---|------------------------------|-----------------------------|
| 1. Do you like your smile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 2. Do you wish your teeth were whiter? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 3. Are you satisfied with the way your gums look? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| 4. Would you like to discuss options to enhance your smile? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Patient Contact Information

 Last First Middle Date of Birth

Mailing Address: _____ City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Single Married (Spouse's Name: _____) Widowed Divorced Separated

Children (Names/DOB): _____ / _____
 _____ / _____

Employer: _____ Position/Title: _____

How did you hear about our office? Personal Referral: _____
 Other: _____

Person Responsible for Account: _____ Relationship to Patient: _____

Mailing Address: _____ City: _____ Zip Code: _____

Employer: _____ Position/Title: _____

Primary Dental Insurance

Employee/Subscriber Name: _____ Soc. Sec. #: _____

Date of Birth: _____ Relationship to Patient: _____

Insurance Company Name and Address: _____

Group #/Policy #: _____ Phone: _____

Secondary Dental Insurance

Employee/Subscriber Name: _____ Soc. Sec. #: _____

Date of Birth: _____ Relationship to Patient: _____

Insurance Company Name and Address: _____

Group #/Policy #: _____ Phone: _____



Acknowledgement of Receipt of Notice of Privacy Practices (You May Refuse to Sign This Acknowledgement)

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA") I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
2. Obtain payment from third-party payers.
3. Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand 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 this organization at any time at the address above to obtain current copy of the Notice of Private 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 operation. I also understand you are not required to agree to my requested restriction, but if you do agree then you are bound to abide by such restriction.

Print Patient Name: _____
 Relationship to Patient: _____
 Signature: _____ Date: _____

Request for Confidential Communications

Name of Patient _____ Date _____

I request that all communication to me by _____ and/or his staff be handled in the following manner:

*Written communications: Addressed to: _____

If the address provided above is not your home address or is not a street address, please provide us with a street address for purposes of ensuring payment: _____

*Oral communication: Call:

- | | | | |
|--|-------------------------|------------------------------|-----------------------------|
| Home # _____ | May we leave a message? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Work # _____ | May we leave a message? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Cell # _____ | May we leave a message? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| May we leave a message that you need pre-medication? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| May we leave a message that you have a dental appointment? | | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices acknowledgement, but was unable to do so as documented below

Date: _____ Initials: _____ Reason: _____

Payment Information

Name (please print)

Date

Thank you for choosing Envisia for your dental needs. Our commitment is to provide you the highest standard of comprehensive dental care that you deserve. Prior to treatment we will provide you with an estimate of your total costs.

Our goal is to help you afford your dental choices. Please take a moment to review the financial options we have designed for your benefit.

A. Payment prior to treatment with cash, check or credit card (MC or Visa). Senior Citizens (65 years of age and older) receive a 5% courtesy for payment with cash or check.

B. Monthly payments through Care Credit. We gladly assist you with the application during your appointment time.

C. Insurance. Our goal is to help you maximize your dental insurance benefits. As a courtesy, we are happy to bill your dental plan for services provided. Please remember that the contract itemizing your dental benefits is between you, your employer, and your insurance carrier. Regardless of coverage, your payment is due in full the day of treatment unless Washington Dental Service or Delta Dental Plans are your provider. In that case you will be asked to pay a deposit at the time of treatment equal to your *estimated* portion. Please remember that your dental insurance plan is not designed to cover all your dental needs. Rather, the amount your dental plan contributes towards your dental care is based on the plan selected and purchased by your employer.

Please feel free to contact any member of our staff if you have questions regarding the payment options described above. We thank you for trusting us with your dental care.

Should the need for additional treatment arise during the course of the original treatment plan, the fees may change. Be assured we will notify you of the fee changes and obtain your approval prior to treatment.

I understand and accept full financial responsibility for this account and for all dentistry performed on my dependants in this office. I understand it is up to me to confirm my insurance eligibility, waiting periods and benefits. I also understand that this office can not guarantee my insurance status in any of these areas. Any insurance estimate or information given to me by this office is not a guarantee of actual insurance payment. I also understand that any insurance claim not paid in full after 60 days will become my responsibility to pay at that time.

Patient Signature

Staff Signature

Date: _____

Medical History

Although dental personnel primarily treat the area 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 relationship with the dentistry you receive. Thank you for answering the following questions.

| | | | |
|-----------------------------|-------|---------------------|------|
| | | | |
| Last | First | Middle | Date |
| Date of Birth: _____ | | Email: _____ | |
| Name of Physician: _____ | | Phone Number: _____ | |
| In Case of Emergency: _____ | | Phone Number: _____ | |

Please Indicate If You've Had or Currently Have Any of the Following:

- | | | |
|---|--|---|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Low Blood Pressure |
| <input type="checkbox"/> Alzheimer's/Dementia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial Joint | <input type="checkbox"/> Hepatitis A, B, or C | <input type="checkbox"/> Psychological Problems |
| <input type="checkbox"/> Artificial Valve | <input type="checkbox"/> Herpes Simplex Virus | <input type="checkbox"/> Radiation/Chemotherapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Recurrent Infections |
| <input type="checkbox"/> Auto Immune Disease | <input type="checkbox"/> Hyperthyroid | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Hypothyroid | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Inflammatory Rheumatism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Other Serious Illnesses: _____ |
| <input type="checkbox"/> Drug/Alcohol Treatment | <input type="checkbox"/> Liver Problems | _____ |

Have You Ever Had Any Unusual Reactions/Allergies to the Following Drugs:

- | | | |
|--|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Acetaminophen | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Sulfa |
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Sulfites |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Latex | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Dental Anesthetic | <input type="checkbox"/> Penicillin | _____ |

List All Medications You Are Taking: (including over the counter drugs, herbals and vitamins)

| | | |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

Do you use tobacco? Yes (type: _____) No

Women: Are you... Pregnant Nursing

Do you have any special instructions from a physician regarding pre-medication for dental work? _____
 Is there anything regarding your health that would be important for us to know before starting treatment? _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in my medical status.

Signature of Patient or Parent/Guardian _____ **Date** _____

**I authorize the use of my (or patient's) study models and/or photographs for lectures or publications by Lowell W. Hanson, DDS _____ (INITIAL)