MILLWOOD FAMILY DENTAL
ORDINARY PEOPLE WITH EXTRAORDINARY SMILES

Date_____

First Name_____ M____ Last_____Cell_____Home_____

Preferred name _____E-mail_____ @ gmail hotmail yahoo msn icloud aol comcast.net

Address_____City_____State_____ Zip code_____

Social Security#_____ Birth date: _____ Age_____ Male_____Female _____

Best way to confirm your appointments? Phone Call _____ Text _____ Email _____

Employer_____ Emergency contact_____Phone_____

Former Dentist_____ Phone_____Date of last Exam_____

Whom can we thank for referring you to our practice? Another Patient (Name) _____

Internet_____Location_____Our Website_____Facebook_____Work_____Insurance Co_____Other_____

Check if you have any concerns with the following:

Periodontal	**Esthetics**	**Function**
_____Bad Breath	_____Color/Whiteness	_____Clicking or popping jaw
_____Periodontal treatment	_____Straightness of teeth	_____Sensitivity to sweets
_____Bleeding gums	_____Broken fillings	_____Grinding or clenching teeth
_____Food collection between the teeth	_____Size/Length of teeth	_____Sensitivity to hot / cold
_____Loose teeth	_____Old and discolored fillings	_____Occlusion/Bite

Any dental concerns today? _____Yes _____No *Explain*_____

Do you have dental Anxiety? _____Yes _____No *If yes what has helped*_____

What do you do on a routine basis to take care of your teeth_____

What about the appearance of your smile would you change_____

Are you interested in whitening your teeth? _____Yes _____No What has your experience been with whitening aids?_____

If you have Joint Pain what makes it hurt?_____

Do you use tobacco Products? _____Yes _____*No* *If yes what type and how long*_____

Medical History

Pre-medication: Any history of the following: **Artificial Joints** _____**Mitral Valve** _____**Heart Murmur** _____**Rheumatic/Scarlet Fever** _____

Have you ever been instructed by a physician to take an **antibiotic** (Pre-med) before dental procedures? Yes _____ No_____ Unsure_____

Do you have High Blood Pressure? Yes_____ No_____ If yes, is it controlled well and how?_____

BP_____/_____ (taken in office) **2nd BP**_____/_____

Are you currently being treated by a Physician? Yes_____ No_____ Physician's Name: _____Phone #_____

If yes, Please explain_____

Check if any of the following apply:

_____Pregnant	_____AIDS / HIV Positive	_____Epilepsy	_____Material Allergies
_____Nursing	_____Artificial Joints	_____Fainting	_____Osteoporosis
_____Birth Control	_____Arthritis	_____Food Allergies	_____Pacemaker / Heart Surgery
	_____Asthma	_____Glaucoma	_____Psychiatric Care
_____CPAP	_____Anxiety	_____Headaches	_____Respiratory disease
_____Sleep Apnea	_____Back Problems	_____Heart Murmur	_____Rheumatic Fever
_____Dry mouth	_____Blood Disease	_____Hemophilia/Prolonged bleeding	_____Stomach problems
	_____Cancer	_____Hepatitis	_____Surgical Implant
_____Parkinsons	_____Chemical Dependency	_____High Blood Pressure	_____Thyroid Disease
	_____Chemotherapy/Radiation	_____Jaw Pain	_____Tobacco Habit
_____Other	_____Circulatory problems	_____Kidney / Liver Disease	_____Tuberculosis
	_____Diabetes	_____Mitral Valve Prolapse	_____Venereal Disease

Do you have any history of being treated with **Bisphosphonates** (Fosamax, Boniva, Actonel, Skelid)? _____

Do you have any health problems that need further clarification? If yes please explain: _____

List drug allergies, if any:_____

List any **medications** you are taking:_____

_____ X_____ _____

Print Name of Patient **Patient / Guardian Signature** **Date**

Millwood Family Dental
Mark A. Jensen, DMD
3018 North Argonne
Spokane, WA 99212
(509) 928-5444

Insurance Information

(Self, Spouse, Partner, Parent information required)

Primary Insurance Plan

Name of Insured:_____ Is insured a patient? __Yes __No

Insured Date of Birth:_____ Social Security #_____

Home Phone #:_____ Cell #:_____

Insured Employer Name:_____

Patient's relationship to Insured: __Self ___Spouse ___Child ___Other_____

Insured Plan name, address and phone #:_____

Secondary Insurance Plan

Name of Insured:_____ Is insured a patient? __Yes __No

Insured Date of Birth:_____ Social Security #_____

Home Phone #:_____ Cell #:_____

Insured Employer Name:_____

Patient's relationship to Insured: __Self ___Spouse ___Child ___Other_____

Insured Plan name, address and phone #:_____

Consent Statement

Your first visit: To insure quality care, all new patients will receive a complete examination of their oral tissue and teeth. We will also take comprehensive x-rays, measure the supporting gums to evaluate the health of you tissue, and screen for oral cancer. We may also include other diagnostic aids, such as study models, photographs, etc., to help determine the type of cleaning and treatment you will need.

I hereby authorize and request the performance of dental services for myself or for:_____.

I also give my consent to any advisable and necessary dental procedures, medications or anesthetics to be administered by Dr. Jensen or his supervised staff for diagnostic purposes or dental treatment. These records may include study models, photographs, x-rays, and blood studies. *I understand and acknowledge that I am financially responsible for the services provided for myself or the above names, regardless of insurance coverage*. Treatment plans involving extended credit circumstances are subject to a credit check. I also understand that the treatment estimate presented to me is only an estimate. Occasionally, the need may arise to modify treatment, and in such a case, I will be informed of the need for additional treatment, and it's fee modification.

I understand this office will help me utilize my insurance benefits. Ultimately I am responsible for knowing my insurance plan and paying all balances less after insurance pays.

To the best of my knowledge the information provided in this form is accurate.

_____	X_____	_____
Print Name of Patient	**Patient / Guardian Signature**	**Date**

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Financial Policy

We are proud that our fees reflect the excellent service and care we provide. Dental treatment is an excellent investment in an individual's medical & psychological well-being.

In order to make your treatment affordable, we have set up the following financial arrangements for our patients.

- We accept Cash or Check
- We accept Visa, MasterCard, Discover, & American Express
- Care Credit – Payments can be set up for an extended period of time; interest rates do apply depending on length of loan. (OAC)

A 5% courtesy reduction will be applied towards the appointment if co-payment is over $500 and is paid in full (with cash or check**, insurance co-pays are not included**) prior to the scheduled appointment.

***** PAYMENT IS DUE ON THE DAY OF TREATMENT *****
(Less estimated insurance payment)

We are happy to process most insurance claims. Each plan utilized in our office has different percentages, deductibles, maximums, procedures covered and varying fees that the plan will allow. We will do our very best to make as close a calculation as possible regarding what your insurance plan will cover. However, as we cannot estimate precisely, there may be variances for which the patient is individually responsible. Your dental benefits are determined by a contract between your employer and the insurance company.

Cancellation Policy

We require a 24 hour notice to cancel appointments to avoid a $50 cancellation fee

We understand that sometimes circumstances arise that prevent patients from keeping their appointments. It happens to the best of us! If you find it impossible to keep an appointment, please notify our office within 24 hours of your appointment. With this prior notice, we can reschedule your appointment and let another patient have the appointment time originally reserved for you.
We request this courtesy because it allows us to see our patients promptly. It also helps us provide more affordable dental care for all of our patients.

*****If you are unable to give us 24 hour notice, we reserve the right to charge $50 for missed appointments (_____)**
Patient/Guardian Initials

We appreciate your cooperation and understanding.

Thank you for reviewing our financial and office policies. Feel free to ask Dr. Jensen or his team any questions you may have regarding the above policies.

I have read, understand and agree to the above financial and office cancellation policies.
I authorize my insurance company to pay my dental benefits directly to Millwood Family Dental.

Print Name of Patient	X_____ Patient / Guardian Signature	Date

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Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Millwood Family Dental. 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 the respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Millwood Family Dental reserves the right to change the privacy practices that are 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 to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

- ANY MEMBER OF MY IMMEDIATE FAMILY YES____ NO____
- SPOUSE ONLY YES____ NO____
- OTHER (please specify)_____ YES____ NO____

_____ X_____ _____

Print Name of Patient **Patient / Guardian Signature** **Date**

Office Use Only Below This Line

Record of Acknowledgement Not Obtained:
( ) Provided Prior to Treatment Yes__ No__ Date Provided: _____

Reason for Denial:
( ) Individual Refused to Sign
( ) Unable to Sign
( ) Reason Not Given
( ) Needed more time to review Statement of Privacy Practices
( ) Wanted to consult with another person prior to signing
( ) Other (Explain) _____