North Harbor Dentistry

Date 1/4/2018

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel 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, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

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 medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

Date_____ **Confidential Responsible Party Information** A B C

Name_____ Marital Status_____
Last First Middle

Residence_____ ☐ Own ☐ Rent
Street City State Zip

Mailing Address_____ Email_____
Street City State Zip

Would you like a confirmation via ☐ Email ☐ Text

How long at this address_____ Previous Address_____
(if less than 3 yrs) Street City State Zip

Home Phone_____ Work Phone_____ Cell Phone_____

Social Security #_____ Birthdate_____ Relationship to Patient_____

Employer_____ Occupation_____ No. Years Employed_____

Spouse's Name_____
Last First Middle

Employer_____ Occupation_____ No. Years Employed_____

Social Security #_____ Birthdate_____ Work Phone_____

Confidential Patient Information

Patient's Name_____
Last First Middle

Address_____
Street City State Zip

Home Phone_____ Birthdate_____ Social Security #_____

If patient is a minor, give parent's or guardian's name_____

Insurance Information

Policy Holder's Name_____ and Soc.Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name_____ and Soc. Sec. #_____

Insurance Company_____ Group No._____ Union Local No._____

Insurance Co. Address_____ Insurance Co. Phone_____

Policy Holder's Employer_____

Emergency Information

Name of nearest relative not living with you_____

Complete Address_____

Phone_____ Relationship:_____

How did you hear about us? Phonebook ☐ Facebook ☐ Ad ☐ _____ Other ☐ _____

I understand that where appropriate, credit bureau reports will be obtained.

Signature (Parent's signature if minor)_____

Updates (date & initial)_____

CONFIDENTIAL (for record and pretreatment evaluation)

NORTH HARBOR
DENTISTRY

Acknowledgment of Privacy Practices

North Harbor Dentistry
14315 62nd Ave NW
Gig Harbor, WA 98332
253-851-4025

THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

My signature confirms that I have been informed of my rights of my privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used too:

- Provide and coordinate my treatment among a number of health care providers who may be involved in treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare operations such as quality assessment and improvement activities.
- Notify me of my upcoming appointments by phone message, text, email, and mail.
- Outside laboratories may be used.
- Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care.

I have been informed of my dental providers Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such 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 healthcare operations and I understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Patient signature/legally authorized representative Date

_____ _____

Printed name if signed on behalf of the patient Relationship

Dependent family members also covered by this acknowledgment:

_____

NORTH HARBOR
DENTISTRY

Financial Policy

We, the staff of North Harbor Dentistry thank you for choosing us as your dental provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our patients' financial responsibility is vital to that provider-patient relationship and our goal is not only to inform of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies, or responsibilities please feel free to contact our office at any time.

We believe this level of communication and cooperation will allow us to provide quality care to our valued patients.

Please understand that payment for services is an important part of the provider-patient relationship. If you do not have insurance, proof of insurance, or participate in a plan that will honor assignment of insurance benefits, payment for services will be due at the time of service unless payment arrangements have been made and approved in advance by our staff. Any copayments, coinsurance, and deductibles will also be due at the time of service. We do our best as a courtesy to estimate any costs associated with treatment but if payment is not paid in full by insurance the responsibility is the patients.

We make payment as convenient as possible by accepting (cash, checks, money order, MC, Visa, Discover, Amex, and Care Credit). A $35.00 service fee will be charged for all returned checks.

Interest
Interest of 1.8% will incur if a balance remains unpaid after 60 days.

Insurance
Please remember that your insurance policy is a contract between you and your insurance carrier. We will, as a courtesy, bill your insurance and help you receive the maximum allowable benefit under your policy. We have found that patients who are involved with their claims process are more successful at receiving prompt and accurate payment of services from their insurance carrier. We do expect patients to be interactive and responsible for communicating with your insurance carrier and any open claims.

It is your responsibility to provide all necessary insurance eligibility, identification, authorization and referral information and to notify our office of any information changes when they occur. Even a preauthorization of services does not guarantee payment from your insurance carrier. We also require photo identification when accepting insurance information. It is the patients responsibility to know if our office is participating or non-participating with their insurance plan. Failure to provide all required information may necessitate patient payment for all charges. When insurance is involved, we are contractually obliged to collect copayments, coinsurance, and deductibles, as outlined by your insurance carrier.

Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing reductions. Our fees are well within such ranges and although we will assist in the filing of an appeal if these limitations are imposed, you as the guarantor are responsible for all out-of-network fees. If we are not contracted with your carrier, we will not negotiate reduced fees with your carrier.

Missed Appointments
We require notice of cancellations 48 hours in advance. This allows us to offer the appointment to another patient. If you fail to keep your appointments without notifying us in advance: a missed appointment fee will apply. These fees are typically $75 per hour but not to exceed one-half of the cost of your scheduled appointment. Repeated missed appointments without proper notification may cause you to be discharged from the practice so that we can provide care to other patients.

Timeliness of Appointments
We try to see everyone in a timely manner but if we are taking too long, please let our receptionist know so we can best serve your needs and reschedule if necessary.

I have read and understand the above financial policy. I agree to assign insurance benefits whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

_____ _____

Patient signature/legally authorized representative Date

_____ _____

Printed name if signed on behalf of the patient Relationship

NORTH HARBOR
DENTISTRY

Consent Form

Patient Name: _____ Date: _____

1. **MEDICAL HISTORY AND MEDICATIONS INFORMATION**
   Please understand that it is important that you divulge any information about your medical history to your dentist. It is important that you inform us of any medicines/drugs that you are taking each time that you come to an appointment as some medications can cause harmful reactions with dental anesthetics, analgesics, antibiotic, or other medications. Please be sure to provide us with a list of any allergies you have.
2. **X-RAYS AND PHOTOS**
   The initial visit may require radiographs in order to complete the examination, diagnosis, and treatment plan. Modern dental x-ray equipment is extremely low-dose radiation. Diagnostic x-rays provide the dentist with valuable information about your teeth and supporting bone that cannot be evaluated otherwise. Our office takes the minimum x-rays to allow us to do a thorough exam for each patient. Without these x-rays, we cannot do a complete exam of the entire mouth and jaw. We may also take photos of our patients as part of their permanent record. We will not release these photos to anyone without your permission.
3. **MEDICATION ADMINISTRATION AND SEDATION**
   I have been informed and understand that anesthetics, analgesics, and antibiotics and other medications used in dentistry, although rare, can cause allergic reactions including redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness, lack of awareness and coordination which can be increased by the use of alcohol or other drugs. Failure to take medications in the manner prescribed may offer risks of continued or aggravated infection and pain and potential resistance to effective treatment. I understand that antibiotics can reduce the effectiveness of oral contraceptives (birth control pills). I have informed the Dentist of any known drug allergies.
4. **RESTORATIONS**
   I understand that care must be exercised in chewing on fillings during the first 24 hours to avoid breakage. I understand that sensitivity is a common after effect of a newly placed fillings. In the case of patient having deep decay near the tooth nerve, there is a high risk of developing sensitivity and the need for root canal treatment may arise. If this need occurs during the decay removal, the dentist will discuss further treatment options with the patient.
5. **CROWNS AND BRIDGES**
   I understand that it is not always possible to match the color of natural teeth or adjacent teeth with crowns/bridges. I further understand that I may be wearing temporary crowns/bridges, which may come off and that I must be careful to ensure that they are kept on until the permanent crowns/bridges are permanently cemented. I understand that I must have permanent crowns/bridges

cemented permanently within one month of the beginning of their preparation. If I do not, I accept responsibility for additional procedures resulting from my delay, including but not limited to: root canal therapy and/or replacement of my crowns/bridges as they may not fit or can re-decay. I realize that the final opportunity to make changes in my new crowns/bridge (including shape, fit, size, and color) will be before permanent cementation. As these procedures have been advised by my treating dentist, I give my treating dentist and appropriate staff my understanding of the risks and benefits while I am a patient in their office

6. **DENTAL PROPHYLAXIS (CLEANING)**
   I understand the treatment involves the removal of plaque and calculus above the gum line and will not address gum infections below the gum line called periodontal disease. In case of diagnosis of periodontal disease, the dentist will discuss further treatment options with the patient.
7. **DENTAL SCALING**
   This can also be known as: gross debridement, deep scaling, deep cleaning, quadrant scalings, dental scalings, and periodontal maintenance scalings. These procedures are to clean and/or aid in the rehabilitation of the gums, teeth, and underlying bony structures. Periodontal disease is often chronic and asymptomatic. Upon completion of, or during these procedures, I may have sensitive gums or teeth, especially around the interface between the teeth and gums. Often, gum line sensitivity is noticed for a few hours to several days after these procedures. Occasionally, soft tissue or gum swelling may occur. Should any of these conditions arise and not subside within a few days of these procedures, I will contact my treating dentist for advice and potential follow up treatment. Sometimes these procedures uncover dental conditions, which were not readily apparent at an initial exam. These procedures are often part of the diagnostic procedure to determine dental conditions I may have.
8. **SPECIFIC PROBLEM EXAMINATION**
   In the event that a patient requests only a specific problem to be addressed (i.e.: broke tooth, pain in one area, etc.) this is considered a problem focused evaluation. X-rays will be taken in this specific area only, and a complete comprehensive examination will not be done. In this case, the dentist cannot diagnose problems in other areas of the mouth. Please understand that this appointment will be for the treatment/diagnosis of an emergency/urgent need. Any future treatment of other areas will require additional x-rays and a comprehensive exam.
9. **CHANGES IN TREATMENT PLAN**
   I understand that during treatment, it may be necessary to change or add a procedure because of conditions found while working on teeth that could not be discovered during examination. A more extensive treatment plan than originally diagnosed and proposed may be required due to additional decay or unsupported tooth structure found during preparation of the tooth. This may lead to other measures necessary to restore the tooth to normal function including the need for root canal, crown, or both. I do authorize the performance of additional procedures and changes planned procedures if, in the judgement of the doctor, this will be necessary to improve my safety and result. I give permission to the dentist to make any/all changes and additions as necessary after discussion with a dentist.
10. **COMPLICATIONS**
    Complications resulting from the use of dental instruments, drugs, sedation, medicines, analgesics (pain killers), anesthetics, and injections include (but are not limited to) swelling, sensitivity, bleeding, pain, infection, numbness and tingling sensation in the lip, tongue, chin, gums, cheeks and teeth (which is transient but on infrequent occasion, may be permanent). Although extremely rare, such

conditions as Bell's Palsy and Trigeminal Neuralgia may occur due to use of injections and local anesthetics. Reaction to injections, changes in occlusion (bite), jaw muscle cramps and spasms, temporomandibular (jaw) difficulty, referred pain to ear, neck, and head, nausea, vomiting, allergic reactions, delayed healing and treatment failure are a possible risks of any dental procedure.

11. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMD)**

I understand that popping, clicking, locking, and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility.

12. **SPECIALTY REFERRAL AND/OR SECOND OPINION**

General dentists perform the majority of all dental treatments today. However, we want all patients to be aware that specialty fields exist in dentistry, particularly in the fields of oral surgery, orthodontics, periodontics, pediatric dentistry, and endodontics. In some cases, we may have to refer certain procedures out to a specialist. We would be happy to offer you the name of a specialist in order for you to have a second opinion and/or have actual treatment performed by a specialist.

ACKNOWLEDGEMENT

I hereby authorize the dental staff of North Harbor Dentistry to proceed with and perform the dental restorations and dental treatments as explained to me. I understand that this is only an estimate and subject to modification depending on unforeseen or un-diagnosable circumstances that may arise during the course of treatment. I understand that dentistry is not an exact science and although favorable results are expected, no guarantee or warranty of expectations, refunds of any kind, either expressed, or implied, has been made. This is due to human variables associated with individual healing and responses to surgery and recovery. Likewise, I understand that, although unexpected, risks and complications can occur. The associated risks of surgery and anesthesia have been explained to me.

I understand that regardless of any dental insurance coverage I may have, I am responsible for payment of dental fees. I agree to pay any attorney's fees, collection fees, or court costs that may be incurred to satisfy this obligation. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfactions. I consent to allow staff of North Harbor Dentistry to take x-rays and perform an examination on me today.

_____ _____

Patient signature/legally authorized representative Date

_____ _____

Printed name if signed on behalf of the patient Relationship