

ADVANCED METROPOLITAN DENTISTRY

1220 Howell Street Ste. 110, Seattle, WA 98101 (206) 464-9002

PATIENT INFORMATION

PATIENT NAME (Last, First, Middle Initial)		DATE OF BIRTH	AGE
ADDRESS		SOCIAL SECURITY NUMBER	
CITY, STATE, ZIP		Male Female	GENDER
HOME PHONE	CELL PHONE	Self Spouse Child	RELATIONSHIP TO INSURED
EMPLOYER		WORK PHONE	
OCCUPATION		E-MAIL ADDRESS	
EMERGENCY CONTACT/NAME		PHONE	

Check appropriate Box: Minor Single Married Divorced Widowed Separated

Prefer: Morning Appointments Afternoon Appointments

How did you hear about our office?

INSURANCE INFORMATION

PRIMARY COVERAGE		SECONDARY COVERAGE	
SUBSCRIBER'S NAME		SUBSCRIBER'S NAME	
DATE OF BIRTH		DATE OF BIRTH	
INSURANCE COMPANY		INSURANCE COMPANY	
SSN# /ID NUMBER	GROUP NUMBER	SSN# /ID NUMBER	GROUP NUMBER
GROUP NUMBER		GROUP NUMBER	
INSURANCE ADDRESS		INSURANCE ADDRESS	
EMPLOYER		EMPLOYER	
OCCUPATION		OCCUPATION	

PRIVACY / CONTACT

DO WE HAVE YOUR PERMISSION TO:

LEAVE A REMINDER REGARDING YOUR APPOINTMENT ON YOUR ANSWERING MACHINE, E-MAIL ADDRESS OR TEXT MESSAGE? Y N

SPEAK WITH OTHER MEMBERS OF YOUR HOUSEHOLD REGARDING YOUR APPOINTMENT OR DENTAL TREATMENT? Y N

IF YES, WHOM: _____ RELATIONSHIP: _____

LEAVE A MESSAGE AT YOUR PLACE OF EMPLOYMENT? Y N

AUTHORIZATION AND RELEASE

Our dental office will gladly assist you in filing your insurance claim, but we are unable to accept responsibility for collecting your claim if there is a dispute. It is your responsibility to pay for the entire amount not covered by your dental benefit plan. By signing this form, you hereby assign all payments for services provided for yourself or dependents to Advanced Metropolitan Dentistry.

All accounts 30 days and over are past due and will be subject to an interest rate of 18% per annum. All collections 90 days past due may be turned over for collection. In the event, you or your insurance company fail to pay and it is necessary to employ outside collections efforts, you are responsible for reasonable costs for collection, including but not limited to court costs, attorney fees and collection agency fees.

Responsible Party's Signature

Date

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PATIENT MEDICAL HISTORY:

Physician Name: _____ Phone: _____ Date of last visit: _____

How long since your last: Dental Visit: _____ Cleaning: _____ X-Rays: _____

1. Are you under medical treatment now?	Yes No	Nature of Care:
2. Have you ever been hospitalized for any surgical operation or serious illness in the last 5 years?	Yes No	Reason:
3. Are you taking blood thinners such as aspirin or Coumadin?	Yes No	Please List:
4. Are you currently taking any medication(s), including non-prescription medications, herbal supplements or diet pills?	Yes No	Please List:
5. Are you required to pre-medicate before dental treatment?	Yes No	
6. Do you use Alcohol?	Yes No	
7. Do you smoke?	Yes No	
8. Are you wearing contact lenses?	Yes No	How often?
9. Have you ever experienced abnormal bleeding?	Yes No	Please Explain:
10. Are you on a restricted diet?	Yes No	How many meals a day? Food Allergies?
11. Women Only: Are you pregnant, or think you may be pregnant? Are you nursing? Are you taking birth control medications?	Yes No Yes No Yes No	Please List:

Are you allergic or have you reacted adversely to the following? (please circle)					
Aspirin	Codeine	Demerol	Valium	Sulfa	Penicillin
Erythromycin	Tetracycline	Latex	Local Anesthetic	Vicodin	Triazolam
Are you aware of being allergic to any other medications or substances? If yes, please list: _____					

Please circle yes or no any of the following which you have now or have had in the past:

Angina Pectoris(chest pain)	NO	YES	Cosmetic Surgery	NO	YES
Heart Disease/Attack/Stroke	NO	YES	Emphysema	NO	YES
Heart Failure	NO	YES	Asthma	NO	YES
High/Low Blood Pressure	NO	YES	Tuberculosis	NO	YES
Congenital Heart Defect	NO	YES	Arthritis /Rheumatism	NO	YES
Heart Murmur	NO	YES	Venereal Disease	NO	YES
Rheumatic Fever	NO	YES	Frequent Headaches	NO	YES
Heart Surgery	NO	YES	Artificial Joints	NO	YES
Heart Pacemaker	NO	YES	Fever Blisters/Cold Sores	NO	YES
Artificial Heart Valve	NO	YES	Fainting	NO	YES
Diabetes	NO	YES	Seizures	NO	YES
Blood Transfusion/Anemia	NO	YES	Hay Fever	NO	YES
Sickle Cell Disease	NO	YES	Shingles	NO	YES
Bruise Easily	NO	YES	Anxiety Disorder	NO	YES
Hemophilia	NO	YES	Psychiatric Treatment	NO	YES
Liver Disease (Jaundice)	NO	YES	Chemical Dependency	NO	YES
Hepatitis: A B C	NO	YES	Glaucoma	NO	YES
Kidney Disease	NO	YES	Cancer	NO	YES
Thyroid Disease	NO	YES	HIV infection/AIDS	NO	YES
Stomach ulcers	NO	YES	HIV Positive/AIDS Related Com.	NO	YES
Lupus	NO	YES			

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release information to you. I will notify the doctor of any changes in my health or medications.

Patient/Parent's Signature: _____ Date: _____

Dr's Signature: _____ Date: _____

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Financial and Office Policy

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstanding, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortable and affordable we have eliminated billings. In order to secure an appointment with Dr. Martini, a deposit is due at the time of scheduling. If you need financial arrangements, we will make every effort to make your treatment affordable. For your convenience we accept Cash, Personal Checks, Visa, MasterCard, Discover Card, American Express and Care Credit.

We will, as a courtesy and service to you, process your insurance benefits in our office. We will estimate your deductible and the portion not covered by your insurance. We request that you authorize that any insurance benefits be paid directly to Advanced Metropolitan Dentistry. You will be responsible for all services not covered by your insurance company. All questions regarding your insurance benefits must be addressed with your insurance carrier.

We understand that unforeseen circumstances can arise regarding your schedule. Please notify our office 2 business days prior to your appointment for any changes. We reserve the right to charge your account \$50 for any appointment that is cancelled or changed with less than 2 business days notice.

Please make your questions and concerns known to our Financial Coordinator, who is happy to discuss the policy with you and ensure that you have an outstanding experience.

Patient's Signature: _____ Date: _____

Optional

If you would like us to keep a credit card on file for future payments, you can complete the section below. We will confirm, with you, that you would like us to use this card before processing any payment, unless other arrangements have been made.

Patient Name: _____

Patient's Signature: _____

Date: _____

Credit Card #: _____

Exp. Date: _____

Check One: Visa MasterCard American Express Discover Card Care Credit

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Notice of Consent

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out the following:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
- Obtaining payment from third party payers (my insurance company).
- The day to day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you agree, you are often bound to comply with the restrictions.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or requires that we do so. You may see your record or get more information about it by contacting our privacy officer.

Print Patient Name: _____

Patient's Signature: _____

Date: _____

Consent for Release of Confidential Information

I authorize the dentist to perform diagnostic procedures and treatment as necessary for the delivery of proper dental care.

I authorize release of any information concerning my (or my child's) health care, for advice and treatment provided for the purpose of evaluation and administration of claims for insurance benefits.

I authorize the release of any information concerning my (or my child's) health care, for advice and treatment to another dentist, or another health care professional and their staff.

Print Patient Name: _____

Patient's Signature: _____

Date: _____

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DOCTOR'S USE ONLY:

Patient' Name: _____ Phone: _____

Date	Time	Blood Pressure			Comments	Initials
		Systolic	Diastolic	Pulse		

Comments on patient interview concerning medical history:

Significant findings from questionnaire or oral interview:

Dental Management considerations:

Dr's Signature: _____ Date: _____