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
ADDRESS		SOCIAL SECURITY NUMBER
CITY, STATE, ZIP		MARITAL STATUS ❒ Single ❒ Married
HOME PHONE	CELL PHONE	SEX ❒ Male ❒ Female
PREFER ❒ Morning Appointment ❒ Afternoon Appointment		RELATIONSHIP TO INSURED ❒ Self ❒ Spouse ❒ Child
EMPLOYER		WORK PHONE
OCCUPATION		E-MAIL ADDRESS

OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE

NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER
NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER

WHO SHOULD BE NOTIFIED LOCALLY IN CASE OF EMERGENCY?

NAME	PHONE
ADDRESS	RELATIONSHIP

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	SSN# /ID NUMBER
GROUP NUMBER	GROUP NUMBER
INSURANCE ADDRESS	INSURANCE ADDRESS
EMPLOYER	EMPLOYER
OCCUPATION	OCCUPATION

UPDATED ON	SIGNATURE	DATE

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

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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 out hope that his 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 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 $85 for any appointment that is cancelled or changed with less than 2 business days' notice. For procedures, your account will be charged $50 per ½ hour.

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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Name: ____ Birth date: ____________ Sex: Male / Female
Physician Name: ______________________________ Phone: ____________________________________
Date of last health care exam: __________What was the exam for? ____________________________________
Have you been hospitalized in the last 5 years? (Please circle) No Yes
If yes, reason: ____
Are you currently receiving care? No Yes if yes, nature of care: ____________________________________
Are you taking blood thinners such as aspirin or coumadin? ____
Are currently taking any medications, prescription or over the counter drugs? No Yes
If yes, please list:____
Are you required to Pre-medicate before dental treatment? No Yes
Are you a smoker? If so, how much do you smoke per day? ____
Are you taking Tagamet (Cimetidine)? No Yes If yes, how often? ____________________________________
Do you take Antacids? No Yes If yes, how often? ____
Are you taking any herbal supplements/medicines? No Yes If yes, which ones? ______________________
____
Have you ever experienced abnormal bleeding? No Yes If yes, please explain__________________________
____

Women: Are you pregnant ? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you nursing? No Yes
Are you taking birth control pills? No Yes
If yes, 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. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.

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			

Diet: Restricted diet: ____________________
How many meals a day: ____________________
Food allergies: ____________________
Sugar in your diet: (Please circle one) None Slight Moderate High

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's Signature: ____________________ Date: __________

Dr.'s Signature: ____________________ Date: __________

DOCTOR'S USE ONLY

Blood Pressure: Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______
Systolic: ______ Diastolic: ______ Pulse: ______ Time: ______ Date: ______

Comments on patient interview concerning medical history: ____________________

Significant findings from questionnaire or oral interview: ____________________

Dental Management considerations: ____________________

Date	Health History Update