Welcome! We're glad you're here.

Today's Date _____

Patient Information

❑ Mr. ❑ Mrs. ❑ Ms. ❑ Dr.

First Name _____ M.I. ____ Last Name _____

Preferred Name _____ Gender ❑ Male ❑ Female

Birth Date _____ Age _____ Soc. Sec. # _____ Email _____

Cell (____) _____ Home (____) _____ Work (____) _____

Home Address _____ Apt/Unit _____

City _____ State _____ Zip _____

Student ❑ Full Time ❑ Part Time ❑ N/A School Name _____

Employed ❑ Full Time ❑ Part Time ❑ Retired ❑ N/A

Employer _____ Occupation _____

United States Armed Forces Member? ❑ Current ❑ Former/Retired Branch _____ Rank _____

Marital Status ❑ Married ❑ Engaged ❑ Single ❑ Widowed

Spouse/Partner _____ Employer _____ Occupation_____

Primary Care Physician _____ Tel. (____) _____

Cardiologist _____ Tel. (____) _____

Preferred Pharmacy _____ Tel. (____) _____ Location_____

Emergency Contact Name _____ Tel. (____) _____ Relationship _____

How did you discover us? (Please check any that played a role - thanks!!)

❑ Friend(s)/Family Member(s) _____ ❑ Location

❑ Google/Search Engine ❑ Our Website ❑ Facebook ❑ Instagram ❑ Twitter ❑ Angie's List

❑ Other _____

Your Hobbies/Passions _____

Health History

The health of your mouth is a very important part of your total wellness. Your health conditions and medications can affect your oral health and the dental care we provide.

Please list the medications you are currently taking (including non-prescription, herbs, and supplements)

Medication	Reason	Medication	Reason
_____	- _____	_____	- _____
_____	- _____	_____	- _____
_____	- _____	_____	- _____
_____	- _____	_____	- _____
_____	- _____	_____	- _____

Height _____ **Weight** _____ lbs

Have you ever had any of the following conditions/treatments? **(please check any that apply)**

- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Heart Attack_____
- ❑ Congestive Heart Failure_____
- ❑ Cardiac Stents_____
- ❑ Cardiac Pacemaker_____
- ❑ Coronary Bypass_____
- ❑ Chest Pain/Angina
- ❑ Congenital Heart Defect
- ❑ Artificial Heart Valve_____
- ❑ Bacterial Endocarditis_____
- ❑ Stroke_____
- ❑ Cancer_____
- ❑ Chemotherapy_____
- ❑ Radiation Therapy_____
- ❑ Family History of Oral Cancer
- ❑ Osteoarthritis
- ❑ Rheumatoid Arthritis
- ❑ Artificial Joint _____
- ❑ Osteoporosis
- ❑ Osteopenia
- ❑ Psoriasis
- ❑ Lupus
- ❑ Thyroid Disease
- ❑ Emphysema
- ❑ Asthma
- ❑ Pneumonia
- ❑ Bronchitis
- ❑ Tuberculosis
- ❑ Respiratory Problems
- ❑ HPV
- ❑ Cold Sores/Fever Blisters
- ❑ Canker Sores
- ❑ AIDS
- ❑ HIV+
- ❑ Chickenpox
- ❑ Shingles
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Hypoglycemic
- ❑ Anemia
- ❑ Hemophilia
- ❑ Bruise/Bleeds Easily
- ❑ On Blood Thinners
- ❑ Hepatitis A
- ❑ Hepatitis B or C
- ❑ Liver Disease
- ❑ Kidney Disease
- ❑ Depression
- ❑ Nervousness/Anxiety
- ❑ Fibromyalgia
- ❑ Vertigo
- ❑ Neck/Back Injury/Pain
- ❑ Epilepsy/Seizures
- ❑ Tension Headaches
- ❑ GI Disorders
- ❑ Acid Reflux
- ❑ Ulcers
- ❑ Snoring
- ❑ Sleep Apnea
- ❑ Colitis
- ❑ Diverticulitis
- ❑ Other _____

_____

_____

_____

For Women

- ❑ Pregnant _____ Weeks
- ❑ Trying to Get Pregnant/ In Treatment
- ❑ Nursing
- ❑ Prescription Birth Control

Have you ever had an allergic or adverse reaction to any of the following?

- ❑ Adhesive Bandages
- ❑ Acrylic
- ❑ Any Metals (Nickel, etc.)
- ❑ Aspirin
- ❑ Codeine
- ❑ Erythromycin or Clindamycin or Azithromycin
- ❑ Eugenol (Clove Oil)
- ❑ Ibuprofen
- ❑ Latex
- ❑ Local Anesthetics
- ❑ Nitrous Oxide
- ❑ Penicillin or Amoxicillin
- ❑ Sedatives (Valium, Xanax, Versed, Sodium Pentothal, etc.)
- ❑ Sulfa Drugs (Septra, Bactrim, etc.)
- ❑ Tetracycline or Doxycycline
- ❑ Other _____

Have you ever:

Taken Fosamax, Boniva, Actonel, or other medications containing bisphosphonates Osteoporosis/Osteopenia?

❑ No ❑ Yes When was your the last dose? _____

Had a physician ever recommended that you take antibiotics prior to your dental treatment?

❑ No ❑ Yes If yes, please elaborate:

Who recommended the antibiotic _____ Tel. (____) _____

For what reason _____

For how long _____

Check if you are currently using any of the following products and for how many years.

- ❑ Cigarettes_____
- ❑ Cigars _____
- ❑ Pipe _____
- ❑ Smokeless Tobacco _____
- ❑ E-cigarettes/Vaporizers _____
- ❑ Quit _____ Approx. # _____ years ago

Dental History

Former Dentist _____ City/State _____
Approximate Date of Last Visit _____

Do you currently have or have you ever had in the past any of the following?
(please check **ONE** box for any relevant condition)

Current	Past	Current	Past
❑	❑ Braces	❑	❑ Sensitivity to Cold
❑	❑ Invisalign Treatment	❑	❑ Sensitivity to Hot
❑	❑ A Serious Injury to Mouth, Jaw, or Face	❑	❑ Sensitivity to Air
❑	❑ Jaw Clenching	❑	❑ Sensitivity when Biting
❑	❑ Teeth Grinding		
❑	❑ Jaw Joint Popping, Clicking, or Grating		
❑	❑ Jaw Joint Aching or Tiredness		
❑	❑ Difficulty Opening or Closing Your Mouth		
❑	❑ A Night Guard/Bite Splint		
❑	❑ Your Bite Adjusted		
❑	❑ Gums Bleed When Flossing or Brushing		
❑	❑ Receding Gums		
❑	-- Gums Feel Tender or Swollen		
❑	❑ Periodontal Treatment (Deep Cleanings) or Surgery		
❑	-- Family History of Dentures or Periodontal Disease		
❑	❑ Bad Breath		
❑	❑ Wisdom Teeth Extractions		
❑	❑ Other Missing Permanent Teeth		
❑	❑ Loose Teeth		
❑	❑ Teeth/Bite Shifting		
❑	-- Gaps or Spaces Between Your Teeth		
❑	-- Turned, Crowded, or Crooked Teeth		
❑	❑ Broken/Worn/Chipped Teeth or Restorations		
❑	-- Areas That Trap Food or Shred Floss		
❑	-- Teeth That Appear Too Small, Short, Large, or Long		
❑	-- Prior Dental Work That Appears Unnatural		
❑	-- Crowns/Bridges That Appear Dark at the Gum Line		
❑	-- Gray, Black, or Silver Fillings in Your Teeth		
❑	-- A “Gummy” Smile (Too Much Gums Show When Smiling)		
❑	❑ Yellow, Stained, or Discolored Teeth		
❑	-- The Appearance of Your Teeth Often Inhibits You From Smiling or Laughing		
❑	❑ Difficulty Chewing Comfortably on Both Sides of Mouth		
❑	❑ Dry Mouth		
❑	❑ Mouth Breathing		
❑	❑ Occasional Cavities		
❑	❑ Frequent Cavities		
❑	❑ Lingering Sores or Growths in Your Mouth		

How often do you brush your teeth? (please check any that apply)

❑ 3 or more x /day ❑ 2 x /day ❑ 1 x /day ❑ 0 x /day

How often do you floss? (please check any that apply)

❑ Daily ❑ Occasional

How often do you use other dental aides?

❑ Daily ❑ Occasional

What home care aides do you use? (please check any that apply)

❑ Electric Toothbrush
❑ Manual Toothbrush - Soft Bristles
❑ Manual Toothbrush – Medium Bristles
❑ Manual Toothbrush - Hard Bristles
❑ Traditional Floss
❑ Woven/Spongy Floss
❑ Floss Picks
❑ Floss Threader
❑ Proxabrush
❑ Rubbertip Stimulator
❑ Waterpik (a.k.a. Waterflosser)
❑ AirFloss
❑ Mouthrinse

	Lowest										Highest
Please circle the approximate level of your CURRENT oral health:	0	1	2	3	4	5	6	7	8	9	10
Please circle the level of oral health that you would ultimately like to achieve:	0	1	2	3	4	5	6	7	8	9	10
Please circle the level of fear/anxiety that you have about your dental visits:	0	1	2	3	4	5	6	7	8	9	10

Is there a particular dental trigger or negative past experience responsible for that anxiety?
If so, please feel free to describe:

_____

_____

Please check only THREE things about your dental care that you feel are most important to you.

❑ Achieving and Maintaining the Healthiest Mouth Possible
❑ Friendly and Courteous Staff
❑ Excellence and Quality of Dental Services
❑ Freedom From Pain
❑ Financial Options
❑ Seat Me On Time
❑ Office Environment, Cleanliness, Modern Equipment, etc.
❑ Clear Communication and Expectations
❑ Listening to My Concerns and Making Decisions Together With Me Regarding My Treatment Plan
❑ Other_____

When discussing my treatment plan, I prefer…

❑ A Broad Overview
❑ Specific Details

Primary Dental Insurance

Insured Party's First Name _____ Last Name _____ Gender: ❑ Male ❑ Female
Birth Date _____ Employer _____ Relationship to Patient _____
Ins. Co. Name _____ Ins. Co. Tel. (___) _____ Group # _____ ID # _____

Facts About Dental Insurance Benefits

As an optimal-care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance benefits with you.

- **FACT 1: Your dental insurance benefit is based upon a contract between your employer and the insurance company.** Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or the insurance company directly.
- **FACT 2:** Dental insurance benefits differ greatly from traditional medical health insurance benefits and can vary quite a bit from plan to plan. When dental insurance plans first appeared in the early 1960's most plans had a yearly maximum of $1000. Today, some 50 years later, most plans still have an annual maximum of $1000-$1500. Your premiums have increased, but your benefits have not. **Therefore, dental insurance was never set-up to cover your services 100%; it is only an aid.**
- **FACT 3:** You may receive a notification from your insurance company stating that dental fees are "higher than usual and customary." Insurance companies **never** reveal how they determine "usual and customary and reasonable" (UCR) fees. A recent survey done in the state of Washington found at least eight different UCR fee schedules for one zip code in the Seattle area. The fees are somehow determined by taking "a percentage" of an average fee for a particular procedure in a geographic area. Average has been defined as "the worst of the best" or "the best of the worst." **We only provide the "best of the best."**
- **FACT 4:** Many plans tell their participants that they will be covered "up to 80% or up to 100%," but do not clearly specify plan fee schedule allowances, annual maximums, or limitations. It is more realistic to expect dental insurance benefits to cover 35% to 50% of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. **You get back only what your employer puts in, less the profits of the insurance company.**
- **FACT 5:** Many routine dental services are not "covered" by insurance plans. **This does not mean they aren't necessary or appropriate, just not a covered benefit.**

Office Policies

Welcome to our family! At our practice we strive to provide you with the very best dental care that dentistry has to offer and to make your visit as convenient and enjoyable as possible. We have adopted several policies as a mutual agreement between you and our practice. Please read and sign below to let us know that you understand them. Thank you!

- We would like to bring to your attention that dental insurance benefits today have become extremely complicated. We will be happy to provide information to support the necessity for treatment and assist you in recovering your benefits; however, knowing your benefits and financial liability is ultimately **your** responsibility. You will be expected to pay your portion as services are provided. Please keep in mind that we can only **estimate** your portion. **If there is a difference after your insurance company has paid, it is your responsibility to pay the difference.** Because the insurance policy is a contract between you and the insurance company, we will not enter into a dispute with your insurance company over a claim. Any balances not paid by the insurance company within 60 days of submission become the patient's responsibility to pay at that time.
- Our office makes recommendations for your health according to your needs which are based upon established ADA guidelines and discussions with you. **Our recommendations are NOT based upon what your insurance company thinks you need!** Remember, they are not health care professionals. They are a **business** with business interests in mind.
- Any secondary dental insurance and any medical insurance claims will be the sole responsibility of the patient to file and recover benefits from.
- Please keep us informed of any changes in your personal information: **insurance, address, email, telephone numbers, health changes, and medication information.**
- Britten Dental Associates will make every effort to make your appointments at a convenient time for you. We call, email, and text as a **courtesy reminder only** . **Remembering the appointment is ultimately your responsibility.** We require **two business days** notice for changing an appointment. If the appointment is on a Monday, notice will need to be given by the Thursday before. **Speaking to a staff member is the only acceptable means for changing an appointment.** Leaving a voice message is **not** sufficient. A broken and/or missed appointment on the Hygiene schedule will result in a charge of $75.00 for each hour of that appointment time. A broken and/or missed appointment on the Doctor's schedule will result in a charge of $100.00 per hour. If either of the above fees has been assessed due to a broken or missed appointment, all future appointments will be pre-paid in full no less than seven days before the appointment. We take our appointments and your care seriously and ask that you do the same. Thank you!
- If a financial arrangement has not been made and the balance is not part of an insurance benefits payment, a balance remaining beyond 90 days from the first billing will accrue interest at a rate of 2.5% per month of the unpaid balance. **There will be a $25.00 charge for all returned checks** . If you are turned over to a collections agency, a collections fee may be added to your account.
- **Cell phones should be turned off or on silent while the patient is in the dental chair.** Whether in the Hygiene chair or in the Doctor's chair, it is important that we have your undivided attention. The Doctors and Hygienists will give all our patients the same respect. We appreciate your cooperation in these matters. Thank you for being a part of our family!

Patient or Legal Guardian Signature _____ Date _____

X-Ray, Photo, Video, and Testimonial Release

Nothing makes us more proud and excited than when our patients achieve superior results from services we have provided for them. Sharing those results with others helps them understand how they too can benefit from those services. We accomplish this by sometimes displaying patient x-rays, photographs, videos, and written testimonials both around our office and on our website/social media pages. Please note that for testimonials your first name and last initial may be used. Also, any consent given would remain valid until revoked in writing.

- ❑ I would be honored to give Britten Dental Associates permission to use any of my x-rays, photographs, videos, and testimonials I have given.
- ❑ I give permission to use my x-rays, testimonials, and close-up photos of my teeth, but not videos or full-face images.
- ❑ I respectfully decline permission.

Patient or Legal Guardian Signature _____ Date _____

Notice of Privacy Practices Acknowledgement

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information.

- ❑ I acknowledge that I have received or read an online copy of this office's Notice of Privacy Practices.

Patient or Legal Guardian Signature _____ Date _____

- ❑ I authorize Britten Dental Associates to share all my protected health information with the following individuals; however, I understand that I may revoke this consent, in writing, at any time; I acknowledge that any use or disclosure that occurs prior to the date I revoke this consent is not affected:

Name_____ Relationship_____ Tel. (____) _____

Name_____ Relationship_____ Tel. (____) _____

Section C: 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 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out: Treatment (including direct or indirect treatment by other healthcare providers involved in my→ treatment) Obtaining payment from third party payers (e.g. 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 requests.