PRECISION DENTISTRY
of Olympia

2728 Westmoor Ct SW , Ste D
Olympia, Washington 98502
360-995-0025
frontdesk@olympiaprecision.com

PLEASE BRING TO YOUR APPOINTMENT:

1. PHOTO ID
2. INSURANCE CARD
3. MEDICATION & SUPPLEMENT LIST

   WE NEED NAME, MG AND HOW OFTEN YOU TAKE IT
4. PAPERWORK THAT WAS MAILED TO YOU
5. IF YOU HAVE TO TAKE ANTIBODITICS BEFORE YOUR APPOINTMENT PLEASE MAKE SURE YOU TAKE IT ONE HOUR BEFORE YOUR APPOINTMENT.
6. IF YOU ARE ON BLOOD THINNER, PLEASE MAKE SURE YOU HAVE A CURRENT REPORT ON WHAT YOUR INR READING IS.

IF YOU HAVE ANY QUESTIONS, PLEASE CALL OUR OFFICE AND WE CAN HELP WITH ANY SITUATION.

Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Whom may we thank for referring you? _____

Notify in case of Emergency _____ Home Phone _____

Cell Phone _____ Business Phone _____

Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsibly Employed by _____ Occupation _____

Business Address _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber # _____

Name of other dependents under this plan _____

Dental History

Patient Name _____ Nickname _____ Age_____
Referred by _____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient? _____ Months/Years
Date of most recent dental exam ___/___/___ Date of most recent x-rays ___/___/___
Date of most recent treatment (other than a cleaning) ___/___/___
I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY	YES	NO
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most)_____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age? _____	☐	☐
6. Have you had any teeth removed, missing teeth that never developed, or lost teeth due to injury or facial trauma? _____	☐	☐

GUM AND BONE	YES	NO
7. Do your gums bleed sometimes or are they ever uncomfortable when brushing or flossing? _____	☐	☐
8. Have you ever had or been told you have gum loss, gum disease, or bone loss between your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste, odor in your mouth, or swollen and puffy gums? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or feel them move when chewing? _____	☐	☐
13. Have you experienced a burning, painful sensation, or metallic taste in your mouth? _____	☐	☐

TOOTH STRUCTURE	YES	NO
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little, not enough, or do you have difficulty swallowing or chewing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e., pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐

BITE AND JAW JOINT	YES	NO
21. Does your jaw joint ever have pain, sounds (clicking, crackling, or popping), or experience limited opening or locking? _____	☐	☐
22. Do you feel like you need to pull your lower jaw back, or feel that it is being pushed back when you try to bite your back teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, raw carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed? _____	☐	☐
25. Are your teeth becoming more crooked, crowded, or overlapped? _____	☐	☐
26. Are your teeth developing spaces or becoming more loose? _____	☐	☐
27. Do you have more than one bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together better? _____	☐	☐
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	☐	☐
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
30. Do you clench or grind your teeth together in the daytime/ nighttime or ever make them sore? _____	☐	☐
31. Do you have any problems with sleep (i.e., restlessness or teeth grinding), wake up with a headache or an awareness of your teeth? _____	☐	☐
32. Do you wear or have you ever worn a bite appliance? _____	☐	☐

SMILE CHARACTERISTICS		NO
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (color, spaces, size, shape, display)? _____	☐	☐
34. Have you ever bleached (whitened) your teeth? _____	☐	☐
35. Have you felt uncomfortable or self-conscious about the appearance of your teeth? _____	☐	☐
36. Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

Medical History

Patient Name _____ Nickname _____ Age_____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:		
aspirin, ibuprofen, acetaminophen, codeine _____	☐	☐
penicillin _____	☐	☐
erythromycin _____	☐	☐
tetracycline _____	☐	☐
sulfa _____	☐	☐
local anesthetic _____	☐	☐
fluoride _____	☐	☐
chlorhexidine (CHX) _____	☐	☐
Iodine _____	☐	☐
metals (nickel, gold, silver, _____) _____	☐	☐
latex _____	☐	☐
nuts _____	☐	☐
fruit _____	☐	☐
milk _____	☐	☐
red dye _____	☐	☐
other _____	☐	☐
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g., joint replacement, breast implant) _____	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g., asthma, nasal breathing, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g., sleep apnea, snoring, insomnia, restless sleep, bedwetting) _____	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g., "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g., polycystic ovarian syndrome) _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g., gastric reflux, bulimia, anorexia, celiac disease, Crohn's disease, or any inflammatory bowel disease) _____	☐	☐
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g., bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g., rheumatoid arthritis, lupus, scleroderma) _____	☐	☐

	YES	NO
29. glaucoma	☐	☐
30. contact lenses	☐	☐
31. head or neck injuries	☐	☐
32. epilepsy, convulsions (seizures)	☐	☐
33. neurologic disorders (e.g., Alzheimer's disease, dementia, prion disease)	☐	☐
34. viral infections (e.g., cold sores), bacterial infections (e.g., Lyme disease)	☐	☐
35. any lumps or swelling in the mouth	☐	☐
36. hives, skin rash, hay fever	☐	☐
37. STI/STD/HPV	☐	☐
38. hepatitis (type ___)	☐	☐
39. HIV/AIDS	☐	☐
40. tumor, abnormal growth	☐	☐
41. radiation therapy	☐	☐
42. chemotherapy, immunosuppressive medication	☐	☐
43. difficulties with stress management	☐	☐
44. psychiatric treatment, antidepressants, mood stabilizing medications	☐	☐
45. concentration problems or ADD/ADHD	☐	☐
46. alcohol/recreational drug use	☐	☐

ARE YOU:

47. presently being treated for any other illness	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	☐	☐
49. taking medication for weight management	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics	☐	☐
51. often exhausted or fatigued	☐	☐
52. experiencing frequent headaches or chronic pain	☐	☐
53. a smoker, smoked previously or other (e.g., smokeless tobacco, vaping, e-cigarettes, and cannabis)	☐	☐
54. considered a touchy/sensitive person	☐	☐
55. often unhappy or depressed	☐	☐
56. taking birth control pills	☐	☐
57. currently pregnant	☐	☐
58. diagnosed with a prostate disorder	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

_____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ (1-6)

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Missed Appointment Policy

Missed appointments without cancellation and rescheduling prevent us from providing for your health care needs. If you have schedule conflicts, we will be happy to work with you in rescheduling at a time more convenient for you. **We need a 48 Business Hour notice to cancel or reschedule your appointment or you will be charged $75.00.**

As always, we are interested in your health care and wish to continue providing great health care for you at your request: however, if you continue to miss appointments without advance notice, we will be forced to dismiss you from care in our office.

Sincerely

Dr. Xu

I have read the above policy and understand that charges may occur for missed appointments.

_____ _____

Signature **Date**

_____

Relationship to Patient

_____

Print Patient Name

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Financial Policy

As validated by my signature on the bottom of this form, I understand and agree that:

All patient balances are due Immediately after treatment is rendered. Please ask us if you are interested in learning about third party financing, which may allow you to finance your treatment in low monthly payments.

Should a balance accrue on the account a statement will be sent and payment is to be made, in full, by the date on the statement. If payment is not paid within 30 days Interest may be applied to the entire account balance. A revised statement with the new account balance, payable Immediately, will be sent.

A returned check fee may also be applied and must be payable from you for each check payment returned to us by your bank.

Dental insurance is a contract between the patient, their employer (If applicable) and the Insurance provider. Submitting claims for payment to the insurance provider is a courtesy provided by the dentist, not an obligation. Ultimately, I am responsible for any treatment that is unpaid by the insurance provider. If there Is dental Insurance on the account, I understand that the clinic has established the patient balance based on the information I have provided. Final treatment payment Is subject to the terms and conditions of my insurance provider on the date of service. As such, until payment is received from my insurance provider, no patient payment is final.

Estimates and treatment plans are based upon Information gained from the examination. As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. This is a preliminary estimate only and lab charges (if applicable) have been estimated and included total. Estimates do not take into consideration any money that was billed toward my financial maximum or treatment limits that may have been used at other dental clinics.

A submission to my insurance provider will be sent to determine an approximate final investment. However, it is an estimate only. Final insurance splits may be adjusted upon receiving the predeterminations. Predeterminations from my insurance provider(s) are NOT a guarantee of payment.

As with any dental treatment, there may be unforeseen treatment adjustments and/or complications. The clinic will make an effort to anticipate any changes in the treatment plan and advise me at that time. However, such events are unpredictable. Likewise, the timing or spacing of appointments may need to be modified as needed to accomplish the best result possible.

The clinic will make every effort to accommodate my scheduling needs.

I have read, understand, and agree to the above financial policy for payment of professional fees. I understand that I am ultimately responsible for all fees for services rendered to me and/or my family.

_____ _____

Signature **Date**

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Precision Dentistry of Olympia. 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 respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Precision Dentistry of Olympia reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA.)

Spouse only ☐ **YES** ☐ **NO**

OR

Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses) ☐ **YES** ☐ **NO**

Any Member of my extended family: (i.e. Parents, Grandchildren) ☐ **YES** ☐ **NO**

OTHER: (Name) **Telephone #:** ☐ **YES** ☐ **NO**

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative's signature:

Representative's Telephone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained		
Provided Prior to Treatment?	☐ **YES** ☐ **NO** **Date Statement Provided:**	
Reason for not obtaining patient signature:	☐	**Needed more time to review Statement**
	☐	**Wanted to consult another person before signing**
	☐	**Physically unable to sign**
	☐	**No reason offered**

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Financial Agreement & Consent to Contact

I grant permission and consent to Precision Dentistry of Olympia and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations): (1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf; (2) to leave messages for me and include in any such messages amounts owed by me; (3) to send me text messages or emails using any email address I provided or any phone number associated with me, if provided by me or another person on my behalf; and (4) to use prerecorded or artificial voice messages and/or an automated telephone dialing system (an auto dialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me regarding my account, scheduled services, or related matters. I further agree to provide updated contact information in an effort to avoid unintended disclosure of my information, and I acknowledge that Precision Dentistry of Olympia and its agents, assignees, and contractors will treat any email address or phone number I provide as my private contact information that is not accessible by unauthorized third parties. I understand that communication attempts may be made to my cellular phone during permitted calling hours based on the time zone associated with the phone number provided, unless notified otherwise. I understand that my refusal to provide the information described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

I also acknowledge that it is my responsibility to provide complete and accurate insurance information at the time of my appointment, including information for any secondary or additional insurance coverage. If I have secondary coverage, I must present that information during my visit so that it can be properly verified and coordinated. **If secondary insurance information is not provided at the time of service, I understand that it will be my responsibility to submit any remaining balance to my insurance carrier.** The office will not retroactively bill secondary insurance if the information was not provided at the time of the appointment.

_____ _____

Signature **Date**