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

What would you like us to do today? _____ Are you in dental discomfort today? _____
Former Dentist _____ Address _____
Dentist's Email _____ Phone _____
Date of last dental care _____ Date of last x-rays _____

Check (✓) yes or no if you have had problems with any of the following:

☐Y ☐N Bad breath	☐Y ☐N Food collection between teeth	☐Y ☐N Periodontal treatment	☐Y ☐N Sensitivity to sweets
☐Y ☐N Bleeding gums	☐Y ☐N Grinding or clenching teeth	☐Y ☐N Sensitivity to cold	☐Y ☐N Sensitivity when biting
☐Y ☐N Clicking or popping jaw	☐Y ☐N Loose teeth or broken fillings	☐Y ☐N Sensitivity to hot	☐Y ☐N Sores or growths in mouth

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐Y ☐N
Other information about your dental health or previous treatment _____

Medical History

Physician's Name _____ Phone _____
Date of last visit _____ Have you had any serious illnesses or operations? ☐Y ☐N
If yes, describe _____
Are you currently under physician care? ☐Y ☐N If yes, describe _____
Have you ever had a blood transfusion? ☐Y ☐N If yes, give approximate dates _____
Have you ever taken Fen-Phen/Redux? ☐Y ☐N
Have you ever used a biophosphonate medication? Brand names include Fosamax, Actonel, Atelvia, Didronel and Boniva ☐Y ☐N
Women: Are you pregnant? ☐Y ☐N Nursing? ☐Y ☐N Taking birth control pills? ☐Y ☐N
Check (✓) yes or no whether you have had any of the following?

☐Y ☐N AIDS/HIV Positive	☐Y ☐N Cough, persistent	☐Y ☐N Jaw pain	☐Y ☐N Shingles
☐Y ☐N Anaphylaxis	☐Y ☐N Cough up blood	☐Y ☐N Kidney disease or	☐Y ☐N Shortness of breath
☐Y ☐N Anemia	☐Y ☐N Diabetes	☐Y ☐N Liver disease	☐Y ☐N Skin rash
☐Y ☐N Arthritis, Rheumatism	☐Y ☐N Epilepsy	☐Y ☐N Material allergies	☐Y ☐N Spina Bifida
☐Y ☐N Artificial hearth valves	☐Y ☐N Fainting	(latex, wool, metal,	☐Y ☐N Stroke
☐Y ☐N Artificial joints	☐Y ☐N Food allergies	chemicals)	☐Y ☐N Surgical implant
☐Y ☐N Asthma	☐Y ☐N Glaucoma	☐Y ☐N Mitral valve prolapse	☐Y ☐N Swelling of feet or ankles
☐Y ☐N Atopic (allergy prone)	☐Y ☐N Headaches	☐Y ☐N Nervous problems	☐Y ☐N Thyroid disease or
☐Y ☐N Back problems	☐Y ☐N Heart murmur	☐Y ☐N Pacemaker	malfunction
☐Y ☐N Blood disease	☐Y ☐N Heart problems	Heart surgery	☐Y ☐N Tobacco habit
☐Y ☐N Cancer	Describe _____	☐Y ☐N Psychiatric care	☐Y ☐N Tonsilitis
☐Y ☐N Chemical dependency	☐Y ☐N Hemophilia/Abnormal bleeding	☐Y ☐N Rapid weight gain/loss	☐Y ☐N Tuberculosis
☐Y ☐N Chemotherapy	☐Y ☐N Herpes	☐Y ☐N Radiation treatment	☐Y ☐N Ulcer/Colitis
☐Y ☐N Circulatory problems	☐Y ☐N Hepatitis	☐Y ☐N Respiratory disease	☐Y ☐N Venereal disease
☐Y ☐N Cortisone treatments	☐Y ☐N High blood pressure	☐Y ☐N Rheumatic/Scarlet fever	

Is patient taking any medications? If yes, list all: _____
Does patient have drug allergies? If yes, list all: _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all chargers whether or not paid by insurance.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

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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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Privacy Practices Acknowledgement and Consent

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Bill Medical and/or Dental Insurance and obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been **informed** by you of your *Notice of Privacy Practices* and **acknowledge** that I have been given the right to review your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that you have acted relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date: _____ **Initials:** _____ **Reason:** _____