MEDICAL HISTORY

Patient Name: ____ **Date of Birth:** ____________________

Emergency Contact: ____________________________________ **Phone:** _______________________________

Physicians name: ______________________________________ **Phone:** ________________________________

1. Have you had any medical or hospital care within the past two years? .... ☐ Yes ☐ No
2. Have you taken any medications or drugs during the past two years? .... ☐ Yes ☐ No
3. Are you currently taking any medications, drugs, pills, or herbal remedies, including regular dosages of aspirin?....... ☐ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? .... ☐ Yes ☐ No
   If yes, did you take any of the following? (Check Yes) Fen-Phen☐ Pondimin☐ Redux ☐ Other ☐
   If yes to any of the above, did you have a medical exam for heart issues? .... ☐ Yes ☐ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other similar drugs? .... ☐ Yes ☐ No

WOMEN: Are you pregnant or think you could be pregnant?.. ☐ Yes ☐ No
   Do you use prescription birth control?.. ☐ Yes ☐ No

CHECK ALL THAT APPLY: Do you Smoke: ☐ How Much______ Do you Vape: ☐
Do you drink Alcohol: ☐ How Much______

MEDICATIONS: Please list all current medications, including non-prescription medications: (if more space is needed, please ask the front desk for an additional form)

Name of Medication	Amount/Dosage	Frequency (how often)	Reason for Medication

LIST ALL ALLERGIES:____

7. **Indicate which of the following you have had, or have at present. Please check all that apply**

- ☐ Heart Disease
- ☐ Chest Pain
- ☐ Congenital Heart Disease
- ☐ Heart Murmur
- ☐ High/Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Artificial Heart Valve/Pacemaker
- ☐ Rheumatic Fever
- ☐ Arthritis/Rheumatism
- ☐ Cortisone Medicine
- ☐ Swollen Ankles
- ☐ Stroke
- ☐ Diet (specialized/restricted)
- ☐ Artificial Joints
- ☐ Kidney Trouble
- ☐ Diabetes
- ☐ Thyroid Problems
- ☐ Glaucoma
- ☐ Contact Lenses
- ☐ Emphysema
- ☐ Chronic Cough
- ☐ Tuberculosis
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Hay Fever/Allergy/Hives
- ☐ Sinus Trouble
- ☐ Latex Sensitivity
- ☐ Radiation Therapy
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Tumors
- ☐ Hepatitis A, B, or C
- ☐ AIDS/HIV Positive
- ☐ Cold Sores/Fever Blisters
- ☐ Blood Transfusion
- ☐ Hemophilia
- ☐ Sickle Cell Disease
- ☐ Bruise Easily
- ☐ Liver Disease
- ☐ Neurological Disorders
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ Nervous/Anxious/Depression
- ☐ Psychiatric/Psychological Care
- ☐ Ulcers and Acid Reflux

8. Do you have or have you had any disease, condition, or problem not listed? .... ☐ Yes ☐ No
   If yes, please explain: ____

CONSENT: I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a complete and truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquires set forth above have been answered to my satisfaction. I will not hold my dentist, or any member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

PATIENT or GUARDIAN: ____ **Date:**______________________

PATIENT REGISTRATION FORM

PATIENT INFORMATION

Last Name: ________________________________**First Name:** _________________________ **Middle Initial:** _____

Date of Birth: ____________________ **Sex: M / F** **S.S. #:** _______-_____-_______

Address:____ **City:**_________________**State:**______**Zip:** ___________

Home Phone: ____________________ **Cell:**____________________ **Email:**____________________________________

How May We Contact You (check all that apply): ❑Cell Phone ❑Email ❑Work Phone ❑Home Phone

Married ☐ Single ☐ Divorced ☐ Separated ☐ Domestic Partner ☐ Minor/Student ☐

Spouse's Name: __________________________________ **Date of Birth:** _________________ **S.S.#:** ______-___-______

How did you hear about our practice? _________________________________ **Referred by:** ______________________

EMPLOYER INFORMATION

Employer Name: ______________________ **Occupation:** ___________________ **Work Phone**: __________________

Employer Address: ____________________________________**City:** _______________ **State:** _______ **Zip:**_________

FINANCIALLY RESPONSIBLE PERSON OR PARENT (Complete ONLY if different from patient)

Guarantor Name: ____ **S.S. #:** ________-________-________

Relationship to Patient: ____________ **Date of Birth:** ________________ **Home/Cell Phone:** __________________

Address:____**City:**_________________**State:**______ **Zip:**__________

Employer Name: _______________________________________ **Work Phone:** ________________________

PRIMARY INSURANCE

Name of Insurance Company: _______________________________ **I.D. Number:** _________________________

Claims Address: ____ **Group Number:** _______________________

Policy Holders Name: _______________________________________ **Date of Birth:** _________________________

Subscribers Employer: _______________________________________

SECONDARY INSURANCE

Name of Insurance Company: ______________________________ **I.D. Number:** _________________________

Claims Address: ____**Group Number:** _______________________

Policy Holders Name: ______________________________________ **Date of Birth:** _________________________

Subscribers Employer: _____________________________________

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Dr. Brant Powell. I acknowledge that I am financially responsible for payment whether or not covered by my insurance.

Patient or Guardian:____ **Date:** __________________

Dental History

Patient Name: ____ Date: ________________

Last Dental Exam: ____________________________Last Dental X-Ray: _________________

Last Dental Treatment: ____

Patient Concerns: ____

Please check if you currently have or ever have had the following

Yes	No	
❑	❑	Unhappy with the appearance of your teeth
❑	❑	Unfavorable dental experience-dental fears/anxiety
❑	❑	Have you been informed of implants for missing teeth?
❑	❑	Problems with local anesthetic
❑	❑	Prefer nitrous oxide (laughing gas)
❑	❑	Use sedatives for dental treatment
❑	❑	Gag reflex
❑	❑	Difficulty opening your mouth widely
❑	❑	Clenching or grinding of teeth
❑	❑	Wear a nightguard/mouthguard appliance
❑	❑	Jaw clicking or popping
❑	❑	Chew gum regularly or use breath mints
❑	❑	Orthodontic treatment (braces)
❑	❑	Periodontal treatment (gums)
❑	❑	Unpleasant taste or bad breath
❑	❑	Teeth sensitive to temperature, biting, or sweets
❑	❑	Wear a full or partial denture
❑	❑	Drink soda pop, energy, fruit or sugar drinks

How can we best make you comfortable in the office?

____

FINANCIAL POLICY

Dental treatment is an investment in your overall health.

As a courtesy to our patients, we will submit dental claims to your insurance carrier with all required data. Claim submittal is based upon information provided by the patient, and it is the responsibility of the patient to inform us of changes with their insurance.

An insurance plan is a contract between your employer and the insurance carrier, so it is important that you, the patient, understand the provisions and limitations of your particular plan. Insurance companies continue to decrease the number and percentages of covered services without informing dental providers. In many instances, insurance companies provide the dental providers/administrative staff no individual to speak with.

The administrative team of Pinnacle Dental will provide you with a treatment estimate based upon very limited insurance information provided by your insurance carrier. Please remember that this estimate **is just an estimate**. The patient is responsible for the full charges of each appointment. At *your* request, we will also submit a preauthorization to your insurance carrier on your behalf; however, please note that **a preauthorization is not a guarantee** that your carrier will pay the amount that they have specified. Also note that **preauthorization's come with time limitations,** and many companies will only preauthorize treatment once.

While our office does try to provide you with the most accurate treatment plan possible, unforeseen circumstances can arise which may create treatment revisions, resulting in fee and insurance allowance changes.

We will provide you with an estimate of your uncovered insurance balance, and this amount is due at the time of the appointment. Any balance remaining following payment from your insurance carrier will be billed to the patient and payment in full is expected within 14 (fourteen) days of billing statement submittal. Should your insurance company deny payment, the balance in full is the responsibility of the patient. If your insurance carrier pays more than expected, a refund will be submitted to you from Pinnacle Dental, unless you specify otherwise.

ADDN FEES: Patients cancelling appointments with less than a 24-hour notice **will** be charged a $40 cancellation fee per each appointment. Under RCW 621.3-515 any NSF checks received in our office will incur a $40 NSF fee as long as that fee does not exceed the face value of the check. Effective 01-01-2014 all accounts will incur a 12% annum (1% per month) interest fee. This will start 60 days following treatment date regardless of insurance payment.

Payment Options

1. Payment in full at the time of the appointment

For per visit payments exceeding $250 we do offer a 5% courtesy at the time payment is received (cash or check only) unless you are a participant of a discounted (PPO) plan. Discounted plans generally receive a 10-35% discount already. We carry no cash in the office so exact funds are required.

2. Care Credit or Lending Club

These are interest-free payment plans with options of 6 or 12 months for anything exceeding $300 for Care Credit and $500 for Lending Club. **Care Credit and Lending Club can not be used if we are part of your insurances PPO discount plan.** The administrative team can assist you with information or submittal of information. Please note that this is also a discounted plan and does not receive a 5% courtesy. For more information please visit www.carecredit.com OR www.lendingclub.com/dental

3. VISA, MASTERCARD, and DISCOVER

By signing below, you acknowledge that you have read and understand the financial policy of Pinnacle Dental.

Patient Name: ____

Parent/Guardian: ____

Signature____**Date:** _________________

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Pinnacle Dental
Brant L. Powell DDS
Allenmore Medical Center
1901 S. Union, Suite B6001
Tacoma, Wa. 98405

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

- ❑ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- ❑ Obtain payment from third-party payers for my health care services.
- ❑ Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my provider has the right to change the *Notice of Privacy Practices* and that I may contact this office 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________________ Date: _____________________

Signature: ______________________________________

Relationship to Patient: ___________________________

Dependent family members also covered by this acknowledgement:

____

____

- -

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ❑ The patient refused to sign
- ❑ Communication barriers
- ❑ Emergency situation
- ❑ Other