Welcome to Our Office!

To help us meet all your healthcare needs, please fill out this form completely in black ink. If you have any questions or need assistance, please ask us and we will be happy to help.

Patient Information:

Name: _____Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip Code: _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Parent Name (for patients under 18 years old):_____

When confirming appointments how do you prefer to be contacted? ☐ Phone ☐ Email ☐ Text

How did you hear about our office? (Check All That Apply) ☐ Google ☐ Website ☐ Drive By

☐ Friend: _____ ☐ Other: _____

Emergency Contact Information:

Name: _____ Phone #: _____ Relation to you: _____

What are your main concerns? Expectations? Goals? Fears? _____

_____.

How long has it been since your last dental visit? What Helps? _____

_____.

I understand that I am responsible for payment of services rendered and responsible for paying any co-payments and deductibles that my insurance does not cover. I hereby authorize payment directly to Garden City Dental for the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient, Parent or Guardian Signature: _____ Date: _____

Garden City Dental

Eaglesoft Medical History(Copy)

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic
☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics
☐ None

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Yellow Jaundice ◯ Yes ◯ No			

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosure we may make of your protected health information, and of other important matters about your protected health information. A copy of your Notice accompanies this Consent. We Encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy, we will issue a revised Notice of Privacy Practices, which will contain the change. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Aaron Huang DDS

Telephone: (360) 326-4740

Address: 8311 NE Hwy 99 Ste. 106 Vancouver, WA 98665

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if your revoke this Consent.

(Print Patient's Name)

I, _____, have had full opportunity to read and consider the contents of this Consent Print form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Patient or Guardian's Signature: _____ **Date: _____**

IF THIS CONSENT IS **SIGNED** BY A **PARENT/GUARDIAN** ON BEHALF OF THE PATIENT, COMPLETE THE FOLLOWING:

Parent or Guardian's Name: _____

Relationship to the Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the Patient's chart.

Insurance & Financial Policy

Thank you for choosing us as your dental provider. We are committed to restoring and maintaining your oral health. Please understand that payment of your bill is considered part of the treatment process. The following is a statement of our Financial Policy, which we require you to read and sign prior to receiving treatment.

INSURNANCE

It is important for you to know that, though we bill your insurance company as courtesy to you, the amounts charged to you for all services are ultimately your responsibility. Your insurance policy is a contract between you, your employer, and your insurance company. We are not a party to that contract. We cannot bill your insurance company unless you give us your correct insurance information.

Individual insurance companies determine their allowable fee based on their specific plans. Payment for services are based on the allowable amount determined by your insurance company and will vary depending on your policy. Your policy may ask you, the Subscriber, to pay a deductible, the difference between and covered expenses, and may have certain non-covered services. Services not covered by your insurance will be billed directly to you. Any outstanding balance will need to be paid at all appointments.

We will make reasonable attempts to collect approved benefits from your insurance for period of 90 days following your treatment. However, you are ultimately responsible for your dental bills. You will receive a monthly statement showing the amount outstanding that is your responsibility.

Insurance companies will not furnish the specific amount that they will cover on a procedure. **We provide estimates based on individual needs, and with the limited amount of information your insurance company is willing to provide to us, which are subject to change. We offer this service as a courtesy to you. We accept no responsibility for change on your policy, changes in deductibles, or increased fee schedule.**

IF YOU DO NOT HAVE INSURANCE

If You do not have insurance, it is our policy that you pay the amount of your procedure on your visit. We accept cash, personal check, and most major credit cards.

FEES, PENALTIES, AND INTEREST

A fee of $25.00 is charged for all checks returned from the bank unpaid. A fee of $25 for all credit cards charged back by the merchant unpaid.

It is our policy that you pay for your procedure at the time of the first visit. There will be a 5% interest added to past due amounts every 30 days until payment has been made in full.

Patient's Name:_____

Guardian's Name (if applicable):_____

Patient, Parent or Guardian's Signature:_____ Date: _____

Failed Appointment Policy

We want to thank you for choosing us as your dental office. In order to give your appointment and our community the best care, we ask you review our policy regarding failed appointments.

What is a failed appointment?

1. The patient does not appear to the appointment
2. The patient is more than 15 minutes late for the appointment
3. The patient cancels without giving reasonable notice. We ask for 24 hour notice regarding rescheduling or cancellations.

What if you fail to appear to your appointment?

Unestablished patients that fail two consecutive appointments will not be seen at our office.

An established patient that accumulates more than 3 failed appointments within 2 years will be dismissed from our dental office.

If the missed appointment was scheduled for prime time (3:00 pm or after), we will not be able to schedule another late afternoon slot until the next appointment is kept.

If more than three members in a family miss their appointments on the same day, we will not be able to schedule the entire family together in the future.

Possible Exceptions:

There may be exceptions to our broken appointment policy. The best thing to do is to keep our staff informed. Please give us a call 24 hours in advance, or as soon as you discover the need to change an appointment. If your family misses an appointment, call us within a day to reschedule.

If you are an established family with our practice and have been dismissed, Garden City Dental, by law, will be available to handle emergencies only for 30 days starting from the date of our dismissal letter. This will allow you time to find a new dentist to care for your children.

Please Note: As a courtesy we make every attempt through text reminders, e-mails and/or phone calls to remind you of upcoming visits. If your address or phone number changes, please update us so that you can continue to receive these reminders. Please remember that you, as the responsible party, are ultimately responsible for you and/or your child's appointment(s) and as such we respectfully ask that you take a moment to record appointments on your calendar or in your phone

Patient's Name:_____

Guardian's Name (if applicable):_____

Patient, Parent or Guardian's Signature:_____Date: _____