South Kitsap Family Dentistry

J. Chris Bock, D.M.D.
Paul G. Hutchinson, D.M.D.
Morgan McClellan, D.D.S.

PATIENT INFORMATION

Last Name _____ First_____ Middle_____
What do you preferred to be called in our office? _____Male/Female (circle one)
Date of Birth _____ Social Security# _____ Marital Status: M S W D
Address _____ City_____ State ____ Zip _____
Home # _____ Work # _____ Cell # _____
Email _____ Best time and place to reach you _____
Occupation _____
Employer _____ Phone _____
Whom may we thank for referring you ? _____

SPOUSE / PARENT or GUARDIAN

Name _____ Relationship to Patient _____
Date of Birth _____ Social Security # _____
Address _____ City _____ State _____ Zip _____
Home # _____ Work # _____ Cell # _____
Employer _____ Phone # _____
Emergency contact (if different) _____ Phone # _____

INSURANCE INFORMATION

Primary Dental Insurance _____
Employee Name _____
Employee SS# / ID# _____
Date of Birth _____
Employer _____
Insurance Address _____
_____
Insurance Phone _____
Group Policy # _____

Secondary Insurance _____
Employee Name _____
Employee SS# / ID# _____
Date of Birth _____
Employer _____
Insurance Address _____
_____
Insurance Phone _____
Group Policy # _____

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NEW PATIENT HEALTH HISTORY

Patient Name: _____ Date of Birth:_____

Medical Doctor's Name:_____ Physician's Ph#_____

Preferred Pharmacy (Name and City) _____

- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Arthritis, Rheumatism
- ❑ Artificial Heart Valves
- ❑ Artificial Joints
- ❑ Asthma
- ❑ Back Problems
- ❑ Bleeding abnormally
- ❑ Blood Disease
- ❑ Cancer
- ❑ Chemotherapy
- ❑ Circulatory Problems
- ❑ Heart Lesions
- ❑ Cortisone Treatments
- ❑ Cough, persistent or bloody
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fainting or dizziness
- ❑ Glaucoma
- ❑ Headaches
- ❑ Heart Murmur
- ❑ Heart Problems
- ❑ Hepatitis ____
- ❑ Herpes
- ❑ High Blood Pressure
- ❑ Low Blood Pressure
- ❑ Jaundice
- ❑ Jaw Pain
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mitral Valve Prolapse
- ❑ Nervous Problems
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Treatment
- ❑ Respiratory Disease
- ❑ Rheumatic Fever
- ❑ Shortness of Breath
- ❑ Sinus Trouble
- ❑ Skin Rash
- ❑ Stroke
- ❑ Swelling of Feet or Ankles
- ❑ Swollen Neck Glands
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Tumor or growth on head or neck
- ❑ Ulcer
- ❑ Venereal Disease
- ❑ Weight loss or gain, unexplained
- ❑ Other _____ _____ _____

Women: Are you now or do you plan to become pregnant? **Yes/No** Due Date:_____

Are you nursing? **Yes/No** Taking birth control pills? **Yes/No**

MEDICATIONS

List any medications you are currently taking and the correlating diagnosis

_____
_____
_____
_____
_____

ALLERGIES

- ☐ Aspirin
- ☐ Barbiturates
- ☐ Codeine
- ☐ Local Anesthetic
- ☐ Latex
- ☐ Iodine
- ☐ Penicillin
- ☐ Sulfa

Metals, if so, type: _____

Other _____

DENTAL HISTORY

Reason for today's visit _____

Former Dentist _____ Phone # _____

Last Dental Visit _____Last Dental X-rays _____

- ❑ Cigarette, pipe or cigar smoking
- ❑ Food collection between teeth
- ❑ Gums, swollen or tender
- ❑ Mouth breathing
- ❑ Chronic or recurrent sinus problems
- ❑ Sensitivity to cold
- ❑ Sensitivity when biting
- ❑ Sensitivity to heat
- ❑ Sensitivity to sweets
- ❑ Clicking or popping jaw
- ❑ Dry Mouth
- ❑ Lip or cheek biting
- ❑ Mouth pain
- ❑ Periodontal treatment
- ❑ Sores or growths in mouth
- ❑ Jaw pain or tenderness
- ❑ Teeth grinding
- ❑ Loose teeth or broken fillings
- ❑ Pain around ear
- ❑ Orthodontic treatment
- ❑ Rigorous sports: football, baseball, wrestling, etc

Other dental concerns _____

Signature _____ Date _____

1953 Pottery Avenue, Port Orchard, WA 98366 (360) 876-6211

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FINANCIAL POLICY

I, the undersigned, understand that I am financially responsible for all charges *whether or not* paid by insurance (if applicable), and that any balance over 90 days is subject to a finance charge of 1% per month (12% annually).

By providing my cellular, landline, or any other number(s), I expressly consent to receiving communications from the providers and staff of South Kitsap Family Dentistry and any collector agents that they are contracted with, at any numbers I provide or that are later acquired for me. These parties may use this information to contact me by live agent, voicemail, text message, using an auto-dialer or other computer assisted technology, pre-recorded message(s), or by any form of electronic communication, including any email address I provide, in connection to my *dental health and financial purposes*.

(If applicable) I, the undersigned, certify that I (and/or my dependent(s)) have insurance coverage and assign directly to South Kitsap Family Dentistry all insurance benefits. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. The information that I have provided is true and accurate to the best of my knowledge.

I am consenting to treatment to be provided to me by the staff of South Kitsap Family Dentistry.

_____ _____

Signature of Responsible Party Date

1953 Pottery Avenue, Port Orchard, WA 98366
(360)876-6211

South Kitsap Family Dentistry

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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 dental 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 dental 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 of 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.

**I authorize South Kitsap Family Dentistry to discuss my treatment and account information with the following*

Name(s) ____

****I do*** ☐ *,* ***I do not*** ☐ *want relevant treatment information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:*

____

Patient Name ____ Date of Birth____________________

Signature ____ Date __________________________

Relationship to Patient _________________________________

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FOR ADULT PATIENTS UNDER THEIR PARENTS INSURANCE *(Please initial one):*

_____**I authorize** _____**I DO NOT authorize** any information regarding my treatment and/or billing and account information to be released to either parent at any time it is requested.

For Office Use Only:

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

☐The patient refused to sign ☐Communication barriers ☐Emergency Situation

☐Other ____

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1953 POTTERY AVENUE
PORT ORCHARD, WA 98366

Telephone (360) 876-6211
Fax (360) 876-7952

CANCELLATION AND NO-SHOW POLICY

A 24-hour notification will be required for all cancelled appointments. Cancellation of an appointment less than 24 hours prior will be considered a No Show and will result in a cancellation fee. Office policy states that you will be withdrawn from the practice for 3 missed appointments per family. A warning letter will be sent after your first missed appointment.

Signature _____ Date_____

Printed Name _____

The above signed acknowledges receipt of cancellation/no show policies

Family members also covered by this acknowledgement

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

Patient Name:_____ DOB:_____

*Appointment reminders via text and email are automated.
Please call our office for any changes to your current appointments.