INTRODUCTIONS

Steve Carstensen DDS

Patient's Name______________________________ **Preferred name?**____________ SS# _____-____-______

Address____ City/State/Zip ______________________________

Phone - H(____)______________ W(_____)______________ Birthdate ____________ Marital Status ________

E-mail ________________________ Emergency Contact Name and Number _________________________

Employer ________________________ What do you do there? _________________________________

GETTING TO KNOW YOU

Why do you seek dental care now? ____

Whom can we thank for referring you? ______________________________ Family____ Friend____ Co-Worker ___

How long since your last dental visit? ___________________ What was done? ____________________________

Is there anything you would like to change about your smile, or any other part of your mouth? What would that be?

____

Please describe your long term goals for the health of your mouth and teeth _________________________________

What dental services have you had? Please indicate with a ✔

Cleanings _____ Fillings _____ Extractions _____ Root Canals ______ Caps or Crowns ______ Braces ______

Treatment of Gum Disease ______ Cosmetic Bonding _____ Bleaching _____ Implants ______ TMJ ________

Other:_____________ Have you postponed recommended treatment? _____ Tell me more about that ____________

____

Have you had problems or undesirable experiences with previous dental treatments? __________________________

What can we do to make you most comfortable? ____

Is there anything else you would like us to be aware of? ____

____

PERSONAL HEALTHCARE ISSUES

Do you use any tobacco products? ________ What and how much per day?____________ How long?____________

Do you snore loud enough that someone has commented on it?_______ Are you tired during the day? _______ Has anyone been concerned about your breathing during sleep? __________ Is your blood pressure is high? _______________

How often do you use your Toothbrush? ________ Type ________________Toothpaste?________ Brand___________

Floss? _________ Type __________________ Toothpick? __________ Other? ____________________________

Are you aware of any medical problems? __________ Are you under care of a healthcare provider? _____________

May we consult with them? _________ Name and phone # ____

Women: Are you pregnant? __________ Month? ________ Nursing? ____________ Taking birth control pills? _________

Please list any medications, vitamins, or supplements you are currently taking: ____________________________

____

PLEASE CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

☐ Heart Disease or Attack	☐ Whiplash	☐ Diabetes	☐ Epilepsy
☐ Artificial Heart Valve	☐ Artificial Joints	☐ Diabetes in Family	☐ Fainting or Dizzy Spells
☐ Heart Murmur	☐ Arthritis	☐ Asthma	☐ HIV Positive / AIDS
☐ Rheumatic Fever	☐ Cortisone Therapy	☐ Tuberculosis	☐ Thyroid Disease
☐ High Blood Pressure	☐ Jaw Joint Pain	☐ Hay Fever/Allergies	☐ Glaucoma
☐ Pacemaker	☐ Hepatitis A, B, or C	☐ Sinus Trouble	☐ Cosmetic Surgery
☐ Stroke	☐ Liver Disease	☐ Chronic Cough	☐ Chemotherapy
☐ Angina	☐ Kidney Disease	☐ Cold Sores	☐ Radiation Therapy
☐ Bleeding Disorders	☐ Ulcers	☐ Numbness or Tingling Sensations	

Allergies To: ☐ Aspirin ☐ Codeine ☐ Penicillin ☐ Erythromycin ☐ Tetracycline ☐ Sulfa
☐ Local Anesthetics (Novocaine) ☐ Latex ☐ Other ________________________
☐ Contact Allergies – like metals or plastics _______________________

Have you ever been told to take a medication before dental treatment? Y N

ACCOUNT INFORMATION ☐ **Already Provided**

Benefits Through Your Employer	**Benefits Through Another Person's Employer**
Insurance Co. Name _____________________________	____
Insurance Co. Address ___________________________	____
Group # ________________	Group # ________________

Other Person's Name ____________________________________ S S # _____-_____-______ Birthdate _________________

Relationship to Patient ______________ Address if different ____

ACKNOWLEGEMENT AND RELEASE

To the best of my knowledge the above information is correct. I will inform this office of any changes.

I **Consent** to the taking of photographs and X-rays before, during, and after treatment and to the use of same by the doctor in scientific presentations or demonstrations.

Insurance: We provide services for our patients with the understanding that they are responsible for payment in accordance with our financial policy. We will prepare and submit forms and reports to assist you in obtaining maximum benefits available, but in no case are treatment recommendations or fees affected by the presence or absence of insurance benefits. I authorize my insurance benefits to be paid directly to the dentist.

Collections: In the event the balance becomes more than 60 days overdue, billing may be turned over to an outside collection agency. The responsible party listed above agrees to pay interest, collection and other legal expenses related to collection of fees owed. Waiver of any breach of any time or condition shall not constitute a waiver of any further term or condition.

Signature ____ Date _________________

(Parent or guardian if patient is a minor)

Steve Carstensen DDS

FINANCIAL AGREEMENT

We are pleased to offer you the following payment options:

- **CASH OR PERSONAL CHECK**
- **PERSONAL CREDIT AND DEBIT CARDS**

  VISA
  MasterCard
  Discover
  American Express

- **FINANCING OPTIONS**

  Care Credit

Please ask our administrative staff for details

Patient/guarantor agrees to and understands the following:

- ❑ Payment is due at the time of service.
- ❑ Patient/guarantor is responsible to pay at the time of service. If treatment is covered by insurance, your patient portion/deposit is required by the patient/guarantor.
- ❑ As a service to our patients, we will contact your insurance carrier for your dental benefits. However, w**e are not responsible for any incorrect or incomplete information provided to us by your insurance company.**
- ❑ Patient is responsible to pay all charges not covered by insurance, including any fees considered above their insurance carrier's usual and customary fee schedule.
- ❑ The office will submit a claim up to two times; further insurance appeal becomes the responsibility of the patient/guarantor.
- ❑ Patient/guarantor is responsible for balance in full after 60 days regardless of expected insurance or third party payments.
- ❑ Patient/guarantor authorizes their insurance benefits to be paid directly to the doctor.
- ❑ Patient/guarantor authorizes the doctor or insurance company to release any information required for any claim.
- ❑ I have received a copy of this financial agreement.

____

Signature (Responsible Party)　　　　　　　　Date

NOTICE OF PRIVACY ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain right 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.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physicians certifications.

I have received, read and understand your *Notice for Privacy Practice* 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 below 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 understand you are not required to agree to my requested restrictions, but if you do not agree then you are bound to abide by such restrictions.

Patient Name: ____ Relationship to Patient:_________________

Signature:____ Date:_____________________________

OPTIONAL: I agree you may share information related to my treatment, healthcare, financial and Insurance details with:

Name____ Relationship to Patient: ___________________

Name____ Relationship to Patient: ___________________

Steve Carstensen DDS
14420 Belred Rd Suite 107
Bellevue, WA 98007

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: