

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

HOME PHONE: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

CELL PHONE: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

WORK PHONE: \_\_\_\_\_

**PERSON RESPONSIBLE FOR THE ACCOUNT – PLEASE CHECK ONE:**

PATIENT    SPOUSE    FATHER    MOTHER    LEGAL GUARDIAN

PLEASE CHECK THE FOLLOWING BOX IF YOU DO NOT WANT TO RECEIVE INFORMATION BY EMAIL:

**RELATIONSHIP TO INSURED:**

SELF    SPOUSE    CHILD    OTHER \_\_\_\_\_

SEX:  FEMALE    MALE

**MARITAL STATUS:**

SINGLE    MARRIED    PARTNERED FOR \_\_\_\_\_ YRS

**RESPONSIBLE**

**PARTY'S SSN:** \_\_\_\_\_

PREFERENCE:  MORNING APPT    AFTERNOON APPT

**PERSON TO CONTACT IN CASE OF EMERGENCY (PLEASE SPECIFY SOMEONE WHO DOES NOT LIVE IN YOUR HOUSEHOLD):**

NAME: \_\_\_\_\_

RELATIONSHIP: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_ - \_\_\_\_\_

CONTACT PHONE NUMBER: \_\_\_\_\_

E-MAIL ADDRESS: \_\_\_\_\_

**OTHER MEMBERS OF YOUR FAMILY SEEN BY THIS OFFICE:**

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ SOCIAL SECURITY NO.: \_\_\_\_\_

**\*WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? \_\_\_\_\_**

**INSURANCE INFORMATION**

**PRIMARY**

**SECONDARY**

SUBSCRIBER'S NAME: \_\_\_\_\_

SUBSCRIBER'S NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

INSURANCE COMPANY: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

GROUP NUMBER: \_\_\_\_\_

MEMBER ID #: \_\_\_\_\_

MEMBER ID #: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

OCCUPATION: \_\_\_\_\_

**AUTHORIZATION:**

I hereby authorize payment directly to David Chen, DDS, PS of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment(s). I hereby authorize David Chen, DDS, PS to administer such mediations and perform such diagnostic, photographic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the dental/medical histories are correct to the best of my knowledge. I grant the right to the dentist to release my dental/medical histories and other information about my dental treatment to third party payor's and/ or other health professionals.

**SERVICE CHARGE:**

If I do not pay the entire new balance within twenty-five (25) days of the monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1% per month (or a minimum charge of flat \$5.00 for a balance under \$10.00) which is an annual percentage rate of 12% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

**PATIENT OR**

**RESPONSIBLE**

**PARTY'S SIGNATURE:** \_\_\_\_\_

**PLEASE PRINT**

**NAME:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**DATE:** \_\_\_\_\_

# HEALTH HISTORY

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ AGE: \_\_\_\_\_

NAME OF YOUR PHYSICIAN: \_\_\_\_\_ PHONE NO.: \_\_\_\_\_ DATE OF LAST VISIT TO PHYSICIAN: \_\_\_\_\_

NAME OF PREVIOUS DENTIST: \_\_\_\_\_ DATE OF LAST VISIT TO DENTIST: \_\_\_\_\_

## DENTAL HISTORY

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Specific Dental Concern _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you dissatisfied with the appearance of your teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Apprehensive (fearful) about dental treatment?	<input type="checkbox"/>	<input type="checkbox"/>	Are you interested in teeth whitening?
<input type="checkbox"/>	<input type="checkbox"/>	Were past experiences in a dental office always positive?	<input type="checkbox"/>	<input type="checkbox"/>	Are your teeth sensitive? Hot or cold food/liquid? Sour or sweet?
<input type="checkbox"/>	<input type="checkbox"/>	Problem with effectiveness or bad reactions to dental anesthetic?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any loose teeth?
<input type="checkbox"/>	<input type="checkbox"/>	Do you gag easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your teeth and jaw?
<input type="checkbox"/>	<input type="checkbox"/>	Do you wear dentures?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open your mouth freely?
<input type="checkbox"/>	<input type="checkbox"/>	Does food catch between your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw ever feel tired?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have difficulty chewing your food?	<input type="checkbox"/>	<input type="checkbox"/>	Is there an unpleasant taste or odor in your mouth and/or throat?
<input type="checkbox"/>	<input type="checkbox"/>	Do you chew on only one side of your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)?
<input type="checkbox"/>	<input type="checkbox"/>	Do you avoid brushing any part of your mouth because of pain?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have sores or growths in your mouth? Discuss: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you brush or floss on a routine basis?
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums bleed when you floss?	<input type="checkbox"/>	<input type="checkbox"/>	Did you have a periodontal (gum) treatment? When: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do your gums feel swollen or tender?	<input type="checkbox"/>	<input type="checkbox"/>	Did you have an orthodontic treatment (braces)? When: _____
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever noticed slow healing sores in or about your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you smoke or chew tobacco?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awakening in the morning?	Date of the last Full Mouth Series of X-Rays (18 Small Films or Panoramic): _____		

## MEDICAL HISTORY

YES  NO Are you under a physician's care now? Why? \_\_\_\_\_  YES  NO Do you need to take antibiotic medication prior to dental treatment?

YES  NO Have you ever been hospitalized or had a major operation? DISCUSS: \_\_\_\_\_

YES  NO Are you taking any medication? \*List an medications you are currently taking and the correlating diagnosis: \_\_\_\_\_

Are you allergic to any medications or substance? Please check all that apply:

ASPIRIN  PENICILLIN  CODEINE  BARBITURATES (SLEEPING PILLS)  IODINE  LOCAL ANESTHETIC  SULFA

LATEX  ACRYLIC  METAL  OTHERS: \_\_\_\_\_

WOMEN (PLEASE CHECK):  PREGNANT/ OR TRYING TO GET PREGNANT: DUE DATE \_\_\_\_\_  NURSING  TAKING CONTRACEPTIVE

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THE APPROPRIATE BOXES.

\*IF YES TO ANY OF THE STARRED CONDITIONS PLEASE CALL PRIOR TO YOUR APPOINTMENT. PREMEDICATION WITH ANTIBIOTICS MAY BE REQUIRED.

YES	NO	YES	NO	YES	NO	YES	NO	YES	NO					
<input type="checkbox"/>	<input type="checkbox"/>	HEART TROUBLE**	<input type="checkbox"/>	<input type="checkbox"/>	HAY FEVER	<input type="checkbox"/>	<input type="checkbox"/>	CANCER	<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL JOINT**	<input type="checkbox"/>	<input type="checkbox"/>	VENEREAL DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	IRREGULAR HEART BEAT	<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE BLEEDING	<input type="checkbox"/>	<input type="checkbox"/>	TUMORS OR GROWTH	<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATISM	<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/ FEVER BLISTERS
<input type="checkbox"/>	<input type="checkbox"/>	HEART MURMUR**	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	RADIATION THERAPY	<input type="checkbox"/>	<input type="checkbox"/>	LIVER DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	HERPES
<input type="checkbox"/>	<input type="checkbox"/>	ANGINA/ CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HEMOPHILIA	<input type="checkbox"/>	<input type="checkbox"/>	CHEMOTHERAPY	<input type="checkbox"/>	<input type="checkbox"/>	YELLOW JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	DRUG ADDICTION
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK/ FAILURE	<input type="checkbox"/>	<input type="checkbox"/>	SICKLE CELL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH/ INTESTINAL DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS A (INFECTIOUS)	<input type="checkbox"/>	<input type="checkbox"/>	ALCOHOLISM
<input type="checkbox"/>	<input type="checkbox"/>	CONGENITAL HEART DISORDER	<input type="checkbox"/>	<input type="checkbox"/>	SWELLING OF LIMBS	<input type="checkbox"/>	<input type="checkbox"/>	RECENT WEIGHT LOSS/ GAIN	<input type="checkbox"/>	<input type="checkbox"/>	CORTISONE MEDICINE	<input type="checkbox"/>	<input type="checkbox"/>	EPILEPSY OR SEIZURES
<input type="checkbox"/>	<input type="checkbox"/>	MITRAL VALVE PROLAPSE**	<input type="checkbox"/>	<input type="checkbox"/>	SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT DIARRHEA	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS B OR C	<input type="checkbox"/>	<input type="checkbox"/>	STROKE
<input type="checkbox"/>	<input type="checkbox"/>	SCARLETT FEVER	<input type="checkbox"/>	<input type="checkbox"/>	FEAR OF RADIOGRAPH	<input type="checkbox"/>	<input type="checkbox"/>	ULCER	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	CONVULSION
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER	<input type="checkbox"/>	<input type="checkbox"/>	SINUS PROBLEM	<input type="checkbox"/>	<input type="checkbox"/>	EMPHYSEMA	<input type="checkbox"/>	<input type="checkbox"/>	RENAL DIALYSIS	<input type="checkbox"/>	<input type="checkbox"/>	FAINING OR DIZZINESS
<input type="checkbox"/>	<input type="checkbox"/>	ARTIFICIAL HEART VALVE**	<input type="checkbox"/>	<input type="checkbox"/>	LOW BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	LUNG DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	GLAUCOMA
<input type="checkbox"/>	<input type="checkbox"/>	HEART PACE MAKER	<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA	<input type="checkbox"/>	<input type="checkbox"/>	THYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	HYPOGLYCEMIA	<input type="checkbox"/>	<input type="checkbox"/>	NERVOUSNESS
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT COUGH	<input type="checkbox"/>	<input type="checkbox"/>	PARATHYROID DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	EXCESSIVE THIRST	<input type="checkbox"/>	<input type="checkbox"/>	PSYCHIATRIC CARE
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BLOODY SPUTUM	<input type="checkbox"/>	<input type="checkbox"/>	PAIN IN JAW JOINTS	<input type="checkbox"/>	<input type="checkbox"/>	HEART SURGERY	<input type="checkbox"/>	<input type="checkbox"/>	ALZHEIMER'S DISEASE
<input type="checkbox"/>	<input type="checkbox"/>	BRUISE EASILY	<input type="checkbox"/>	<input type="checkbox"/>	TUBERCULOSIS	<input type="checkbox"/>	<input type="checkbox"/>	ARTHRITIS/ GOUT	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ HIV POSTIVE	<input type="checkbox"/>	<input type="checkbox"/>	OTHER _____

TO THE BEST OF MY KNOWLEDGE ALL THE PRECEDING ANSWERS ARE ALL TRUE AND CORRECT. IF I HAVE ANY CHANGES IN MY HEALTH STATUS OR IF MY MEDICATION CHANGES, I WILL INFORM THE DENTIST AND STAFF AT THE NEXT APPOINTMENT WITHOUT FAIL.

PATIENT OR LEGAL GUARDIAN SIGNATURE X \_\_\_\_\_ DATE \_\_\_\_\_

REVIEWED BY DOCTOR \_\_\_\_\_ DATE \_\_\_\_\_ BP \_\_\_\_\_



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 www.DavidChenDDS.com

**CONSENT & NOTICE OF PRIVACY**

**Consent of Treatment**

1. I hereby authorize the doctor or designated staff to take x-ray, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor and mutually agreed upon, for the purposes of diagnosis or educational presentation.
2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care.
3. I consent to the use of appropriate medication and therapy as deemed necessary. I fully understand that using anesthetic agents embodies a certain risk.
4. Lastly, I agree to be responsible for payment of all services rendered on my behalf and that of my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1% finance charge (12% APR) and/or minimum of \$5.00 may be added to my account.

**Notice of Privacy Practices – Acknowledgement**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get information about it by contacting our office manager.

Our **Notice of Privacy Practices** describes in more detail on how your health information may be used and disclosed, and how you can access your information.

**By my signature below I acknowledge receipt of the Notice of Privacy Practices. I also understand and agree to all of the above terms and conditions.**

X \_\_\_\_\_ Date \_\_\_\_\_  
 Signature of patient or authorized representative

\_\_\_\_\_  
 Print Name Relationship to patient

**For Office Use Only**

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

This form will be retained in your medical record.

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## Appointment and Financial Policy

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Our goal is to provide you with optimal oral health care and exceptional customer service with a professional and personal touch. To achieve these goals, we greatly depend on your cooperation and your understanding of our appointment(s) and financial policies. Thank you for choosing us and taking the time to review the following:

### Appointments

Your appointment times are reserved especially for you. Our office hours are flexible – early morning, evening and Saturday appointments are available. **If for any reason you have made an appointment which you cannot keep, please notify us at least 24 hours in advance to the visit during our regular business hours of Monday through Friday. Please notify us at least 48 hours prior to the visit for any Saturday appointments.** This courtesy allows us to make time available to other patients. A charge will be made to your account for any broken appointments and/or repeated cancellations on the day of the appointment. The charge is \$50.00 for an appointment with the hygienist, and a minimum of \$75.00 for any appointment with the doctor. However, any broken Saturday appointments without 48 hours advance notice will incur additional \$50.00 to the minimum charges.

### Financial Policy for All Patients

All payments are due at the time of services rendered unless prior financial arrangement has been made. We accept cash, checks, VISA, MasterCard, and as a courtesy, we also provide third party interest free payment option plan. If the treatment requires multiple appointments, payments may be divided over the number of appointments. For full cash payments in advance on various treatments, 5% courtesy will be extended. A 5% senior citizen discount is also offered, but cannot be combined with the 5% full cash discount. Accounts past due over 60 days, will be assessed with 1% interest charges per month (12% per annum). Minimum of \$5.00 will be assessed for any accounts with balance under \$10.00 each statement period. Should the account be forwarded to collection, you will be responsible for all related collection fees and interest added to your account. We apply a \$30.00 charge to any returned checks.

### Patients with Dental Insurance

Dental benefit plans can vary from company to company with different procedures covered or not covered. Insurance companies base the amounts that they will pay toward your dental treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay only what it allows for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built in to most plans and their required payment is strictly regulated by state law.

We welcome all dental insurance plans. As a complimentary service we will be happy to assist you in insurance filing on any claims. If you are covered by dental insurance, please be sure to provide your insurance information prior to or at the time of your first appointment. This will assist us in preparing a rough estimate of your anticipated out of pocket expenses before beginning treatment. In general, benefits should be assigned to us.

We require that deductible and co-payment portion, the amount not covered by the insurance company, be paid for on the day the services are rendered. If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from the date services are rendered, the amount will then become due and payable by you. We accept cash, checks VISA, MasterCard or we can help you make financial arrangements through, CITI-Healthcard, third-party interest free payment option. We apply \$30.00 charge for returned checks. This agreement shall not be amended orally.

Please be advised both our office and you as the policy beneficiary can be prosecuted if deductibles and co-payments are not collected. Although we will make every effort to help you obtain your benefits, we **cannot guarantee** your insurer will pay.

### Authorization and Release

The patient, parent or guardian who is signing this form is responsible for all account transactions and balances. All outstanding balances shall accrue interest at the rate of 12% per year (interest is compounded).

**If insurance involved:** I authorize payment directly to David Chen, DDS, PS at Juanita Bay Dentistry of group benefits otherwise payable to me. I authorize all credit inquiries deemed necessary in regards to my account.

**I have read, understood and agree to all of the above appointment and Financial policies.**

Signature X \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_