FRED DAHM DENTISTRY
EXCEPTIONAL CARE IN A RELAXED ATMOSPHERE

Thank you for selecting our team for your dental care. We are pleased to welcome you to our practice! To help us better serve you and meet your dental healthcare needs, please complete the following forms. If you have any questions or need assistance, please ask us, we are always happy to help!

PERSONAL INFORMATION

Date: _____

First Name: _____ MI: _____ Last Name: _____ Birthdate: _____

Wishes to be called: _____ SSN: _____

Sex: ☐ Female ☐ Male

Status: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Address: _____

City: _____ State/Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State/Zip: _____

How did you hear about us? _____

RESPONSIBLE PARTY (Person responsible for Account)

Name: _____

Relationship to patient: _____ Birthdate: _____

Address: _____

City: _____ State/Zip: _____

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State/Zip: _____

SSN: _____

CONTACT INFORMATION

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email: _____

Best way for us to reach you? *(please circle)* Home Work Cell Email

In the event of an emergency, who should be contacted?

Name: _____ Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

F. R. Dahm D.D.S. P.L.L.C. / F. Dahm D.D. S. P.L.L.C.
4004 NE 4th Street, Suite 106 Renton, WA 98056 / 1951 152nd Pl NE, Suite 108 Bellevue, WA 98007

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE		SECONDARY INSURANCE	
Name of Subscriber:		Name of Subscriber:	
Relationship to Patient:		Relationship to Patient:	
Subscriber's Birthdate:		Subscriber's Birthdate:	
Subscriber's Address:		Subscriber's Address:	
Subscriber's SSN:		Subscriber's SSN:	
Subscriber's Employer:		Subscriber's Employer:	
Insurance Co:		Insurance Co:	
Group #:		Group #:	
Insurance Co Phone #:		Insurance Co Phone #:	

AUTHORIZATION AND RELEASE

I authorize the dentist to release all information necessary to secure payment of insurance benefits. I authorize and request my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

I understand that my dental insurance carrier may pay less than the actual charges for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. Furthermore, I authorize the assignment of benefits to be paid directly to F. R. Dahm D.D.S., P.L.L.C and F. Dahm D.D.S., P.L.L.C dba Fred Dahm Dentistry.

_____ _____

Signature of Patient or Parent/Guardian if minor ***Date***

Thank you for taking the time to complete this form in its entirety. The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask us, we are always happy to help!

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PATIENT NAME: _____ **DATE:** _____

DENTAL HISTORY (Please answer Yes or No to the following questions)

Chief Dental Concern: _____

Are you nervous about having dental treatment?	☐ Yes ☐ No	Have you been treated for a jaw joint problem?	☐ Yes ☐ No
Have you ever had a bad dental experience?	☐ Yes ☐ No	Do your teeth ever feel loose?	☐ Yes ☐ No
Do you have difficulty or pain when opening (yawning)?	☐ Yes ☐ No	Does food catch in-between your teeth?	☐ Yes ☐ No
Does your jaw get stuck, locked or "go out"?	☐ Yes ☐ No	Any difficulty chewing your food?	☐ Yes ☐ No
Difficulty/pain when chewing, talking or using your jaw?	☐ Yes ☐ No	Have you ever had periodontal disease?	☐ Yes ☐ No
Do you have noises in your jaw joints?	☐ Yes ☐ No	Are your teeth sensitive to cold/heat/etc?	☐ Yes ☐ No
Pain around the ears, temples or cheeks?	☐ Yes ☐ No	Have you had a recent injury to your head/jaw?	☐ Yes ☐ No
Does your bite feel uncomfortable or unusual?	☐ Yes ☐ No	Do you have frequent headaches?	☐ Yes ☐ No
Have you ever been premedicated for dental work?	☐ Yes ☐ No		

How often do you brush? _____ Floss? _____

Are you happy with the way your smile looks? ☐ Yes ☐ No

If not, what would you change about your smile? _____

HEALTH HISTORY (Please answer Yes or No to the following questions)

Are you having any pain or discomfort at this time?	☐ Yes ☐ No	Are you currently taking any medications/drugs?	☐ Yes ☐ No
Do you smoke or use tobacco in any form?	☐ Yes ☐ No	If Yes, please list:	
Have you been hospitalized in the past 2 yrs?	☐ Yes ☐ No		

If Yes, please explain: _____

Have you been under the care of a medical doctor during the past 2 yrs? ☐ Yes ☐ No

Physician Name: _____

Physician's Number: _____

If female, are you:

Pregnant	☐ Yes ☐ No
Taking birth control pills or other hormones	☐ Yes ☐ No
Presently in the menopause ("change of life")	☐ Yes ☐ No
Past menopause	☐ Yes ☐ No

Please list any serious medical conditions that you have had: _____

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MEDICAL CONDITIONS (Please answer Yes or No to the following conditions)

	Y	N
Allergies		
Allergy - Hay Fever		
Allergy - Penicillin		
Allergy - Erytho		
Allergy - Sulfa		
Anemia		
Angina Pectoris		
Anxiety/Depression		
Arthritis		
Artificial Heart Valve		
Artificial Joints		
Asthma		
Blood Disease		
Blood Transfusion		
Bruise Easily		
Cancer		
Congenital Heart Defect		
Cortisone Medicine		
Cosmetic Surgery		
Cough		
Diabetes		
Dizziness		
Drug/Alcohol Addiction		
Emphysema/Asthma		

	Y	N
Epilepsy		
Excessive Bleeding		
Fainting		
Fever Blisters/Cold Sores		
Frequent Headaches		
Glaucoma		
Head Injuries		
Heart Attack		
Heart Disease		
Heart Failure		
Heart Murmur		
Heart Surgery		
Hemophilia		
Hepatitis		
High/Low Blood Pressure		
HIV/Aids		
Jaundice		
Kidney Disease		
Liver Disease		
Mental Disorders		
Nervous Disorders		
Pain in Jaw Joint		
Pregnancy		
Psychiatric Treatment		

	Y	N
Radiation Treatment		
Respiratory Problems		
Rheumatic Fever		
Rheumatism		
Shingles		
Sickle Cell Disease		
Sinus Problems		
Stomach Problems		
Stroke		
Thyroid Disease		
Tuberculosis		
Tumors		
Ulcers		
Venereal Disease		
X-ray/Cobalt Treatment		

Other: (please list)

_____

_____

_____

_____

_____

Are you allergic or had any reactions to the following:

	Y	N	What was the reaction?
Latex			
Aspirin			
Penicillin			
Erythromycin			
Tetracycline			
Codeine			
Sedatives or sleeping pills			
Dental anesthetic			
Any other medications:			

* If yes, what kind?

_____ _____

_____ _____

_____ _____

AUTHORIZATION OF INFORMATION

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize, Dr. Fred Dahm, and/or dental staff to perform the necessary dental services that I may need.

_____ _____

Signature of Patient or Parent/Guardian if minor ***Date***

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ACKNOWLEDGMENT 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 and 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 healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my healthcare services.
- Conduct normal healthcare 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 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 healthcare operations and I understand that you are not required to agree to my requested restrictions, but if you do agree, than you are bound to abide by such restrictions.

PATIENT NAME: _____

Signature: _____ ***Date:*** _____

Dependent family members also covered by this Acknowledgement:

_____

_____

_____

_____

_____

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4004 NE 4th Street, Suite 106 Renton, WA 98056 / 1951 152nd Pl NE, Suite 108 Bellevue, WA 98007
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www.freddahmdentistry.com

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FINANCIAL POLICY

This statement is to inform you of our Financial Policy. We are committed to providing you with the highest quality of dental care using only the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you may fully participate in maintaining optimum oral health. Our Financial Policy is intended to facilitate excellent service to you while minimizing our administrative cost.

All charges you incur are your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company. Our office is not a party to that contract. If payment from your insurance company is not received within 60 days from date of service, you will be expected to pay the balance in full.

As a courtesy to you, we will help you process all your insurance claims. You may direct your insurance company to pay your benefits directly to our office by signing the authorization on the Assignment of Benefits Agreement at the bottom of this form. In order for our office to file your insurance claim, you must bring proof of insurance and notify us of any changes to your policy at each dental appointment.

Payment is due at the time service is provided. Our office accepts cash, personal checks, MasterCard, Visa, Discover and American Express. Outside financing is available through Care Credit upon request and approval.

Returned checks and outstanding balances older than 60 days may be subject to collection fees and finance charges at the rate of 1.5% per month (18% annually).

If you have any questions regarding our Financial Policy, please ask. We are committed to providing you with the most positive experience in dental care.

PATIENT NAME: _____

_____ _____

Signature of Patient or Parent/Guardian if minor ***Date***

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APPOINTMENT POLICY

Our office does require a two (2) business day notice to change or cancel an appointment. In our continued commitment to provide the highest quality of dental care available to all of our valued patients, a $50.00 dollar fee will be applied if we do not receive the proper two (2) business day notice to reschedule or cancel an appointment.

PATIENT NAME: _____

_____ _____

Signature of Patient or Parent/Guardian if minor ***Date***

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