RADIANCE DENTAL

19301 South East 34th Street, Suite 101, Camas, WA, 98607
360-369-6420

PATIENT INFORMATION **TODAY'S DATE:_____**

First Name:_____ Last Name:_____ Middle Initial:_____
Birth Date:_____ Male:_____ Female:_____ Married:_____ Single:_____ Minor: Y N
SS#:_____ Driver's License #:_____
Address:_____ City:_____ State: _____ Zip:_____
Home Phone #:_____ Cell #:_____ Work #:_____
E-mail Address:_____ Best way to reach you:_____
Employer:_____
Other family members seen by us:_____

DENTAL INSURANCE INFORMATION

Primary Insurance Company: _____ Employer:_____
Policy Holder's Name:_____ Birth Date:_____ SS#:_____
Policy Holder's ID #:_____ Group #:_____
Patient Relationship to Policy Holder: Self _____ Spouse _____ Child _____ Other _____

Secondary Insurance Company: _____ Employer:_____
Policy Holder's Name:_____ Birth Date:_____ SS#:_____
Policy Holder's ID #:_____ Group #:_____
Patient Relationship to Policy Holder: Self _____ Spouse _____ Child _____ Other _____

Circle "Yes" if the patient has active Provider One/Apple Health insurance: Y N
If yes, please complete the following:
Patient's Name as shown on insurance card:_____
Client ID #: _____

PARENT/GUARDIAN INFORMATION (if patient is a minor)

Parent/Guardian Name:_____ Relationship to Patient:_____
Birth Date:_____ SS#:_____ Driver's License #:_____
Address:_____ City:_____ State: _____ Zip:_____
Home Phone #:_____ Cell #:_____ Work #:_____

EMERGENCY INFORMATION

Emergency Contact Name:_____ Phone #:_____

REFERRAL INFORMATION

How did you hear about us? _____
If referred by someone, whom may we thank for the referral? _____

PATIENT'S MEDICAL HEALTH

PATIENT NAME:_____ **DATE**:_____

Previous Dentist:_____ Last Visit:_____ Date of last cleaning: _____
Reason for changing dentists:_____
Have you ever had problems with previous dental treatment? Y N If yes, please explain:_____
Do your gums bleed? Y N How many x's per day do you brush? _____ How many x's per day do you floss? _____
Why have you come to see us today? (i.e.: pain, checkup, etc.) _____
Do you now have or have you ever experienced pain/discomfort in your jaw (TMJ)? Y N
Do you smoke or use chewing tobacco? Y N If yes, how long? _____ How often? _____
Have you ever had a facial, head, neck, or back injury? _____

Women: Are you or could you be pregnant? Y N Are you nursing? Y N Are you taking birth control medication? Y N

Are you currently being treated for or have you ever been treated for any of the following? Please circle Y or N for each.

Y N Heart Disease
Y N Heart Murmur/Mital Valve Prolapse
Y N Stroke
Y N Congenital Heart Lesions
Y N Rheumatic Fever
Y N Pacemaker
Y N Stent
Y N Abnormal Blood Pressure
Y N Anemia
Y N Prolonged Bleeding Disorder
Y N Tuberculosis or Lung Disease
Y N Asthma
Y N Epilepsy/Seizures
Y N Hepatitis Type ____
Y N Herpes
Y N Sexually Transmitted /Venereal Diseases
Y N HIV
Y N AIDS
Y N Liver Disease
Y N Kidney Disease
Y N Cancer/Chemotherapy
Y N Tumor or Malignancy
Y N Radiation Therapy
Y N History of Drug Addiction
Y N Arthritis
Y N Infectious Mononucleosis ("Mono")
Y N Diabetes
Y N Hay Fever
Y N Sinus Trouble
Y N Ulcers
Y N Jaundice
Y N Excessive Urination/Thirst
Y N Immune Suppressed Disorder
Y N Hearing Loss
Y N Fainting Spells
Y N Glaucoma
Y N History of Emotional/Nervous Disorders

Y N Implants/Artificial Joints: Hip/Knee _____ Other _____
Y N Major surgery: Operation Type:_____Year:_____ Operation Type:_____ Year:_____
Y N I usually take antibiotic prior to dental treatment.
Y N Have you ever taken Fen-Phen or Redux?
Y N I have consumed alcohol within the last 24 hours.
Y N Take or have taken Bisphosphonates (Fosamax, Boniva, Actonel, Aredia, Zometa, etc.) for Osteoporosis or any other condition?
Y N Do you have any other medical problem or medical history NOT listed on this form?_____

Are you allergic to any of the following? Please circle Y or N for each.

Y N Aspirin
Y N Ibuprofen
Y N Penicillin
Y N Codeine
Y N Latex, Metals, Plastics
Y N Local Anesthetics (i.e.: Novocain, Lidocaine)
Y N Sulfa Drugs/Sulfites/Sulfides
Y N Other Medications
Which ones?_____

Please list all medications you are currently taking:

Med:_____ Condition:_____ Med:_____ Condition:_____
Med:_____ Condition:_____ Med:_____ Condition:_____

Physician's Name:_____ Phone #:_____

Initial medical/dental reviewed by:

Dr.'s Signature:_____ Date:_____

Periodic medical/dental health reviewed by:

Dr.'s Signature:_____ Date:_____

Patient (or) Guardian signature is required:

Patient's Signature:_____ Date:_____

Periodic Medical/Dental Health has been updated by:

Patient's Signature:_____ Date:_____

MISSED APPOINTMENT POLICY

We strive to render excellent dental care to you and all our patients. In attempt to be consistent with this, we have a Missed Appointment Policy. When our office reserves your appointment, we are setting aside a dedicated treatment room and time slot just for you. We certainly understand that occasionally circumstances arise that prevent patients from keeping their appointments. However, if you must reschedule your appointment, our office requires a 24-hour notice for proper cancellation of appointments. This courtesy makes it possible to offer your reserved time slot to another patient who needs it with enough time for them to make the arrangements they need. **An appointment is considered missed if:**

1. **The patient fails to show up for the appointment; or**
2. **The patient is more than 10 minutes late for a scheduled appointment; or**
3. **The patient calls to cancel the appointment without giving the required 24-hour notice.**

Patients with missed appointments will be charged a $35 Missed Appointment Fee. This fee must be paid before any future appointments can be given. Please note that this fee is NOT covered by any insurance plan, and will be your direct responsibility. Repeated cancellations or missed appointments will result in the loss of future appointment privileges.

TREATMENT ROOM POLICY

Family members and friends are required to remain in the waiting lounge. This policy allows Radiance Dental to ensure safety, infection control, patient confidentiality, and the highest quality of care and efficiency to our patients.

Notice to Parent(s)/Guardian(s) of Minor Children: Experts in the field of dentistry universally agree that it is unsafe for infants and minor children to accompany patients into the treatment room. All infants and minor children are required to remain in the waiting lounge, and must be supervised by an accompanying adult at all times. In the event that infants/minors are unable to be supervised by an accompanying adult, appointments will need to be rescheduled, and will be considered a missed appointment. We apologize for any inconvenience this causes, and thank you for helping Radiance Dental maintain a safe environment for all.

PAYMENT & INSURANCE POLICY

We require payment in full at the time service is rendered. We offer a payment plan through Care Credit, which is subject to approval. Please ask our front office staff if you would like to apply.

If you have insurance, we are happy to help you receive your maximum allowable benefits. In order to achieve these goals we need your assistance and your understanding of our Payment Policy. Your insurance benefit is a contract between you, your employer, and the insurance company. This office files your insurance claim as a courtesy to you. Insurance payment estimates are only **estimates** based on the information our office receives from your insurance company. You (not the insurance company) are responsible to our office for all fees for services rendered to you. We will accept payment directly from the insurance company only for the percentage the company will cover and do require that the deductible and non-covered fees be paid at each visit.

You will need to provide our office with your social security number and dental insurance card, unless your total fee is paid in cash at the time of service. Treatment may be postponed if the above are not furnished by the patient.

If you are unable to provide our office with your insurance information prior to your appointment leaving us unable to verify your insurance benefits, you will be responsible for the total charge of your visit at the time of your appointment.

TERMS AND CONDITIONS

After explanation by the doctor, I hereby authorize the performance of dental services upon the patients named in this Registration Form, and whatever procedures that the judgement of the doctor may dictate in order to carry out these procedures. I also authorize and request the administration of any anesthetics and x-rays as may be deemed necessary and advisable by the doctor. This office depends upon the reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. All emergency dental services, or any dental services performed without prior financial arrangement must be paid for at the time services are performed. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company. I hereby authorize this office to release information necessary to secure payment. Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to this office benefits accruing to me under my policy. I understand that all insurance benefits are just estimates, and that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorneys' fees. I grant my permission to you, and all Radiance Dental staff, to telephone me at home, on my cell, or at work to discuss matters related to this form. I have read the above conditions and agree to their content.

Patient Name:_____ Date:_____

Patient/Representative Signature: _____

If Patient is a Minor:

Parent/Guardian Name:_____ Date:_____

Parent/Guardian Signature:_____

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

SECTION A: INDIVIDUAL GIVING CONSENT

Patient Name:_____ Date:_____

If Patient is a Minor, complete the following:
Parent/Guardian Name: _____ Relation to Patient: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. We are also requesting your permission to send appointment reminders via text message, phone call, email, and postcards to the contact information on file.

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 uses and disclosures we may make of your protected health information, and of other important matters about your protected health information.

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

A copy of our Notice is available upon request in our office. We encourage you to request a copy, and read it thoroughly before signing this consent.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us a written and signed notice of your revocation submitted to our office. Please understand that the revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that our office may decline to treat you, or to continue treating you, if you revoke this Consent. In refusing this Consent, we will not be allowed to process your insurance claims.

SECTION C: SIGNATURE

I have read and considered the contents of this Consent form and 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.

Signature: _____ Date: _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

If you would like to give permission to our office to discuss your protected health information with an individual (i.e.: spouse), please complete the following:
Individual's Name: _____Relationship to Patient: _____
Individual's Name: _____Relationship to Patient: _____