



## Welcome

Welcome to our office! We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally. Our philosophy of care governs everything we do for you. It consists of the following key elements:

- ✓ We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- ✓ We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- ✓ We strive to be thorough in everything we do, taking the time to be the best we can be.
- ✓ We are esthetics oriented, helping you look your best, while maintaining optimum comfort, function and health.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you. This will take approximately between 30-60 minutes.

Sincerely,

SWAN DENTAL



**PATIENT INFORMATION**

Date: _____	Phone Number: _____	Alternate Number: _____
Patient Name: _____		SSN# _____
Patient Birth Date: _____	Sex: M F	Patient Marital Status: Single Married Minor Other
Address: _____	City: _____	State: _____ Zip: _____
Responsible Party: _____		Relationship: _____
Reason for Today's Visit: _____		Date of Last Visit: _____
E-mail: _____		

For our patients with dental insurance, please remember that YOU ARE RESPONSIBLE FOR PAYMENT. Remember too that few insurance companies attempt to cover all dental costs. Some pay fixed allowances for certain procedures; others pay a percentage of the charge. It is your responsibility to pay any deductible, co-insurance, or other balance not paid for by your insurance.

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Privacy Practice (HIPPA) Patient Consent Form**



Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient's Rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of the notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment and health care operations. We are not required to agree to this restriction, but if we do, we will honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about your treatment, payment and health care operations. You have the right to revoke this consent in writing signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with Health Insurance Portability and Accountability Act of 1996 (HIPAA).

**The patient understands that:**

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Practices that may be reviewed upon request.
- The practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the use of their health information, but the practice does not have to agree to those restrictions.
- The patient may revoke this consent in writing at any time and all future disclosures will then cease.
- The practice may condition treatment upon the execution of this consent.

In general, the HIPPA privacy rule gives individuals the right to request a restriction on use and disclosure of their protected health information (PHI). The individual is also provided the right to request confidential communications or that the communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. The privacy rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure made pursuant to an authorization request by the individual. Please initial acknowledging that you are aware of the HIPPA privacy rule above. Initial \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICAL HISTORY**



Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dental care you will receive.

Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_  
 Have you ever been hospitalized or had a major surgery?  Yes  No If yes, please explain: \_\_\_\_\_  
 Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_  
 Are you taking any medications, pills, or drugs?  Yes  No If yes, please explain: \_\_\_\_\_  
 Do you use tobacco or consume alcohol?  Yes  No If yes, how often: \_\_\_\_\_

Women: Are you: Pregnant/Trying to get pregnant?  YES  NO Taking oral contraceptives?  YES  NO Nursing?  YES  NO

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  
 Sulfa Drugs  Other If yes, please explain: \_\_\_\_\_  
 Do you have, or have you had, any of the following?

AIDS/HIV Positive	<input type="radio"/> Yes <input type="radio"/> No	Cortisone Medicine	<input type="radio"/> Yes <input type="radio"/> No	Hemophilia	<input type="radio"/> Yes <input type="radio"/> No	Radiation Treatment	<input type="radio"/> Yes <input type="radio"/> No
Alzheimer's Disease	<input type="radio"/> Yes <input type="radio"/> No	Diabetes	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis A	<input type="radio"/> Yes <input type="radio"/> No	Recent Weight Loss	<input type="radio"/> Yes <input type="radio"/> No
Anaphylaxis	<input type="radio"/> Yes <input type="radio"/> No	Drug Addiction	<input type="radio"/> Yes <input type="radio"/> No	Hepatitis B or C	<input type="radio"/> Yes <input type="radio"/> No	Renal Dialysis	<input type="radio"/> Yes <input type="radio"/> No
Anemia	<input type="radio"/> Yes <input type="radio"/> No	Easily Winded	<input type="radio"/> Yes <input type="radio"/> No	Herpes	<input type="radio"/> Yes <input type="radio"/> No	Rheumatic Fever	<input type="radio"/> Yes <input type="radio"/> No
Angina	<input type="radio"/> Yes <input type="radio"/> No	Emphysema	<input type="radio"/> Yes <input type="radio"/> No	High Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Rheumatism	<input type="radio"/> Yes <input type="radio"/> No
Arthritis/Gout	<input type="radio"/> Yes <input type="radio"/> No	Epilepsy/Seizures	<input type="radio"/> Yes <input type="radio"/> No	High Cholesterol	<input type="radio"/> Yes <input type="radio"/> No	Scarlet Fever	<input type="radio"/> Yes <input type="radio"/> No
Artificial Heart Valve	<input type="radio"/> Yes <input type="radio"/> No	Excessive Bleeding	<input type="radio"/> Yes <input type="radio"/> No	Hives/Rash	<input type="radio"/> Yes <input type="radio"/> No	Shingles	<input type="radio"/> Yes <input type="radio"/> No
Artificial Joint	<input type="radio"/> Yes <input type="radio"/> No	Excessive Thirst	<input type="radio"/> Yes <input type="radio"/> No	Hypoglycemia	<input type="radio"/> Yes <input type="radio"/> No	Sickle Cell Disease	<input type="radio"/> Yes <input type="radio"/> No
Asthma	<input type="radio"/> Yes <input type="radio"/> No	Fainting/Dizziness	<input type="radio"/> Yes <input type="radio"/> No	Irregular Heartbeat	<input type="radio"/> Yes <input type="radio"/> No	Sinus Trouble	<input type="radio"/> Yes <input type="radio"/> No
Blood Disease	<input type="radio"/> Yes <input type="radio"/> No	Frequent Cough	<input type="radio"/> Yes <input type="radio"/> No	Kidney Problems	<input type="radio"/> Yes <input type="radio"/> No	Spina Bifida	<input type="radio"/> Yes <input type="radio"/> No
Blood Transfusion	<input type="radio"/> Yes <input type="radio"/> No	Frequent Diarrhea	<input type="radio"/> Yes <input type="radio"/> No	Leukemia	<input type="radio"/> Yes <input type="radio"/> No	Stomach Disease	<input type="radio"/> Yes <input type="radio"/> No
Breathing Problem	<input type="radio"/> Yes <input type="radio"/> No	Frequent Headaches	<input type="radio"/> Yes <input type="radio"/> No	Liver Disease	<input type="radio"/> Yes <input type="radio"/> No	Stroke	<input type="radio"/> Yes <input type="radio"/> No
Bruise Easily	<input type="radio"/> Yes <input type="radio"/> No	Genital Herpes	<input type="radio"/> Yes <input type="radio"/> No	Low Blood Pressure	<input type="radio"/> Yes <input type="radio"/> No	Swelling of Limbs	<input type="radio"/> Yes <input type="radio"/> No
Cancer	<input type="radio"/> Yes <input type="radio"/> No	Glaucoma	<input type="radio"/> Yes <input type="radio"/> No	Lung Disease	<input type="radio"/> Yes <input type="radio"/> No	Thyroid Disease	<input type="radio"/> Yes <input type="radio"/> No
Chemotherapy	<input type="radio"/> Yes <input type="radio"/> No	Hay Fever	<input type="radio"/> Yes <input type="radio"/> No	Mitral Valve Prolapse	<input type="radio"/> Yes <input type="radio"/> No	Tonsillitis	<input type="radio"/> Yes <input type="radio"/> No
Chest Pains	<input type="radio"/> Yes <input type="radio"/> No	Heart Attack/Failure	<input type="radio"/> Yes <input type="radio"/> No	Osteoporosis	<input type="radio"/> Yes <input type="radio"/> No	Tuberculosis	<input type="radio"/> Yes <input type="radio"/> No
Cold Sores/ Blisters	<input type="radio"/> Yes <input type="radio"/> No	Heart Murmur	<input type="radio"/> Yes <input type="radio"/> No	Pain in Jaw Joints	<input type="radio"/> Yes <input type="radio"/> No	Tumors or Growths	<input type="radio"/> Yes <input type="radio"/> No
Congenital Heart Disorder	<input type="radio"/> Yes <input type="radio"/> No	Heart Pacemaker	<input type="radio"/> Yes <input type="radio"/> No	Parathyroid Disease	<input type="radio"/> Yes <input type="radio"/> No	Ulcers	<input type="radio"/> Yes <input type="radio"/> No
Convulsions	<input type="radio"/> Yes <input type="radio"/> No	Heart Trouble/Disease	<input type="radio"/> Yes <input type="radio"/> No	Psychiatric Care	<input type="radio"/> Yes <input type="radio"/> No	Venereal Disease	<input type="radio"/> Yes <input type="radio"/> No
						Yellow Jaundice	<input type="radio"/> Yes <input type="radio"/> No

Have you ever had any serious illness not listed above?  Yes  No  
 Comments:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

### DENTAL HISTORY

Reason for today's visit: \_\_\_\_\_



Former Dentist: \_\_\_\_\_ City/State \_\_\_\_\_

Date of the last dental x-rays \_\_\_\_\_

Place or mark on “yes” or “not” to indicate if you have had any of the following:

- Bad breath Yes \_\_\_\_\_ No \_\_\_\_\_
- Bleeding gums Yes \_\_\_\_\_ No \_\_\_\_\_
- Blister on lips or mouth Yes \_\_\_\_\_ No \_\_\_\_\_
- Burning sensation on tongue Yes \_\_\_\_\_ No \_\_\_\_\_
- Chew on one side of the mouth Yes \_\_\_\_\_ No \_\_\_\_\_
- Cigarette, pipe, or cigar smoking Yes \_\_\_\_\_ No \_\_\_\_\_
- Clicking or pumping jaw Yes \_\_\_\_\_ No \_\_\_\_\_
- Dry mouth Yes \_\_\_\_\_ No \_\_\_\_\_
- Fingernail biting Yes \_\_\_\_\_ No \_\_\_\_\_
- Food collection between the teeth Yes \_\_\_\_\_ No \_\_\_\_\_
- Foreign objects Yes \_\_\_\_\_ No \_\_\_\_\_
- Grinding teeth Yes \_\_\_\_\_ No \_\_\_\_\_
- Gums swollen or tender Yes \_\_\_\_\_ No \_\_\_\_\_
- Jaw pain or tiredness Yes \_\_\_\_\_ No \_\_\_\_\_
- Lip or check biting Yes \_\_\_\_\_ No \_\_\_\_\_
- Loose teeth or broken fillings Yes \_\_\_\_\_ No \_\_\_\_\_
- Mouth breathing Yes \_\_\_\_\_ No \_\_\_\_\_
- Mouth pain, brushing Yes \_\_\_\_\_ No \_\_\_\_\_
- Orthodontic treatment Yes \_\_\_\_\_ No \_\_\_\_\_
- Pain around ear Yes \_\_\_\_\_ No \_\_\_\_\_
- Periodontal treatment Yes \_\_\_\_\_ No \_\_\_\_\_
- Sensitivity to cool Yes \_\_\_\_\_ No \_\_\_\_\_
- Sensitivity to heat Yes \_\_\_\_\_ No \_\_\_\_\_
- Sensitivity to sweets Yes \_\_\_\_\_ No \_\_\_\_\_
- Sensitivity when biting Yes \_\_\_\_\_ No \_\_\_\_\_
- Sores or growths in your mouth Yes \_\_\_\_\_ No \_\_\_\_\_
- How often do you floss? \_\_\_\_\_
- How often do you brush? \_\_\_\_\_

**FACTS ABOUT DENTAL INSURANCE**

As an optimal-care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.



**Fact #1:** Your dental insurance is based upon a contract between your employer and the insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or the insurance company directly.

**Fact #2:** Dental insurance benefits differ greatly from traditional medical health insurance benefits and can vary quite a bit from plan to plan. When dental insurance plans first appeared in the early 1970's most plans had a yearly maximum of \$1000. Today, some 30+ years later, most plans still have an annual maximum of \$1000. That the premiums remained the same, allowing for a conservative yearly rate of inflation, your yearly plan maximums should be in excess of \$4500 today. Your premiums have increased, but your benefits have not. Therefore, dental insurance was never set-up to cover your services 100%; it is only an aid.

**Fact #3:** You may receive a notification from your insurance company stating that dental fees are "higher than usual and customary." Insurance companies never reveal how they determine "usual, customary and reasonable"(UCR) fees. A recent survey done in the state of Washington found at least eight different UCR fee schedules for one zip code in the Seattle area. The fees are somehow determined by taking "a percentage" of an average fee for a particular procedure in a geographic area. Average has been defined as "the worst of the best" or "the best of the worst." We do not provide average dentistry nor do we charge average fees.

**Fact #4:** Many plans tell their participants that they will be covered "up to 80% or up to 100%," but do not clearly specify plan fee schedule allowances, annual maximums, or limitations. It is more realistic to expect dental insurance to cover 35 to 50 of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer puts in, less the profits of the insurance company.

**Fact #5:** Many routine dental services are not covered by insurance companies. This does not mean they aren't necessary or appropriate, just not covered.

We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure that you get every benefit dollar you are entitled to. However, the treatment we recommend and **the fees we charge will always be based on your individual need, not your insurance coverage.** The ultimate decision as to what will be done and how fast we proceed will always be made by you. Based on your decision, we will discuss the total cost of treatment and what assistance you can expect from your dental insurance. 'All arrangements are strictly between you and our office. The full responsibility for payment of services rendered will always be with you.