# WHATCOM DENTAL

1225 East Sunset Drive Suite 140 Bellingham, Washington 98226
Phone: 360-255-5000 Fax: 360-255-5001

Welcome! Please complete the following form for our records. All patient information is confidential.

**Patient Information**

Name: _____ Date: _____
Last First MI Preferred Name

Address: _____
Street Address Apartment #

_____
City State Zip Code

SSN: _____ Birth Date: _____

Phone: _____ _____ _____
Home Work Cell

Email Address: _____

☐ I would like to receive appointment confirmations via text message

☐ I would like to receive appointment confirmations, request appointments & submit surveys via email

Are you (circle): Married Single Child Other: _____

Emergency Contact: _____ Phone: _____

Current Employer: _____ Phone: _____

Employment/Student Status (circle): Full Time Part Time Retired

**Whom may we thank for referring you to our practice? (circle) Another Patient:** _____

Dental Office: _____ Phone Book Online Insurance Company

**Spouse Information**

Name: _____ Address: _____
Male Female (If different from patient's address)

Phone: _____ _____
Home Work Cell

SSN: _____ Birth Date: _____

Employer: _____ Employer Phone: _____

**Insurance Information**

Subscriber: _____ Birth Date: _____ SSN: _____

Insurance Company: _____ Insurance Phone: _____

ID # _____ Group # _____ Employer: _____

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## Medical and Dental Information

Patient Name_____

☐ *Do you, or have you, had any of the following:*

- ☐ AIDS/HIV Positive
- ☐ Alzheimer's Disease
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Angina
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint/ Joint Replacement
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Breathing Problem
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Cold Sores/Fever Blisters
- ☐ Pain in Jaw Joints
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medicine
- ☐ Diabetes
- ☐ Drug Addiction
- ☐ Easily Winded
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/ Dizziness
- ☐ Frequent Cough
- ☐ Frequent Diarrhea
- ☐ Frequent Headaches
- ☐ Genital Herpes
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Pace Maker
- ☐ Heart Disease
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B or C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Hives or Rash
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mitral Valve Prolapse
- ☐ Psychiatric Care
- ☐ Radiation Treatments
- ☐ Recent Weight Loss
- ☐ Recent Surgery
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Scarlet Fever
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Spina Bifida
- ☐ Stomach/ Intestinal Disease
- ☐ Stroke
- ☐ Swelling of Limbs
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors or Growths
- ☐ Ulcers
- ☐ Venereal Disease

**Please circle your answer:**

Do you use tobacco? **Yes / No**

Are you wearing contacts? **Yes / No**

Do you clench or grind your teeth? **Yes / No**

Do you bite your lips or cheeks? **Yes / No**

Have you had any difficult extractions? **Yes / No**

Have you had orthodontic treatment? **Yes / No**

Do you wear partials or dentures? **Yes / No**

Have you ever taken Fen-Phen/Redux? **Yes / No**

Do you have a cough or throat clearing not associated with a known illness lasting more than 3 weeks? **Yes / No**

**For Women Only:**

Are you pregnant or think you may be? **Yes / No**

Are you nursing? **Yes / No**

Are you taking oral contraceptives? **Yes / No**

**Do you ever experience:**

- ☐ Sensitivity to hot/cold substances?
- ☐ Sensitivity to sweet/sour substances?
- ☐ Pain in any of your teeth?
- ☐ Clicking or pain in your jaw?
- ☐ Difficulty opening/closing your jaw?
- ☐ Difficulty chewing?

Have you ever had any serious illness not listed above? **Yes/No**

If yes please explain: _____

Allergies to Medication/ Metal: _____

List all prescription and non-prescription drugs you are taking: _____

_____

I certify that all of the preceding answers and information provided are true and correct. I authorize the dentist to release any information to third party payers and/or health practitioners. By signing, I acknowledge that I have received and reviewed the "Notice of Privacy Policies."

_____

Signature of Patient or Legal Guardian Date

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Thank you for choosing *Whatcom Dental* as your family dental provider. It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility prior to treatment.

**In order to continue providing quality dental care at affordable prices, we require payment in full on the day of treatment.**

***Patients with Insurance:*** **Estimated portions not covered by insurance are due at the time of service.**
***Patients without Insurance:*** **Payment for all dental services is due at the time of service.**

**For Our Patients with Dental Insurance**

Please understand that as your oral health provider it is our responsibility to provide you with the treatment that best meets your needs, not try to match your care to your insurance plan limitations. Insurance plans do not correspond to individual patient needs. Therefore, many routine and individual necessary dental services may not be covered. In spite of what your plan states, we have found that many plans actually pay less than what they have estimated or what you may have expected. We are happy to submit all insurance claims on your behalf to maximize your reimbursement; however this is a service we provide as a courtesy to our patients. ***We are not responsible for the outcome of the transaction***, negotiating or disputing claims. This is the patient's responsibility, as well as any remaining balance at our office not paid for by insurance within 60 days.

**The patient is responsible for all charges and balances on their account.**
A NSF charge of $35.00 will apply on each returned check.

**Appointment Agreement**

When an appointment is scheduled it is a commitment made between the patient and the doctor. *This time is reserved only for you*. Each patient is responsible for honoring their pre-scheduled time with the doctor. If you are unable to honor your appointment, we respectfully request 72 hours advance notice but **REQUIRE 48 business hours' notice. (Business Hours: MON-THURS, 700AM – 500PM)**

All appointments failed without notice will be charged $50.00 per half hour of scheduled operatory time. All appointments cancelled with less than 48 business hours' notice will be charged $50.00 per half hour of scheduled operatory time. If 3 appointments are failed or cancelled without sufficient notice by a family within 1 year, the patient and family will be dismissed from our practice.

Thank you for your understanding and compliance.

_____ _____

Patient or Legal Guardian Signature Date