



New Patient Information

Date _____

Personal Information

Name _____

Date of Birth _____ Age _____ Male Female

Address _____

Email Address(es) _____

Home Phone _____ Cell Phone _____ Work Phone _____

Spouse's Name _____ Spouse's Phone _____

Other Emergency Contact _____ Emergency Phone _____

What is the best method to contact you? _____

Employer _____ Profession _____

How did you hear about us? _____

Previous Dentist

Prior Dentist _____

Address _____ Phone _____

When was your last visit to previous dentist? _____

Your Dental Health - please indicate how the following apply to you

- | | | | |
|--|----------|---|----------|
| Apprehensive about dental treatment..... | Yes / No | Want complete dental care..... | Yes / No |
| Problems with previous dental treatment..... | Yes / No | How often do you brush? _____ | |
| Gag easily..... | Yes / No | How often do you floss? _____ | |
| Wear dentures..... | Yes / No | Jaw makes noise and bothers you or others..... | Yes / No |
| Food catches between your teeth..... | Yes / No | Clench or grind jaws frequently..... | Yes / No |
| Difficulty chewing food..... | Yes / No | Jaws ever feel tired..... | Yes / No |
| Chew on only one side of your mouth..... | Yes / No | Jaw gets stuck so you can't open freely..... | Yes / No |
| Avoid brushing any part of your mouth..... | Yes / No | Hurts when chewing or opening wide to bite..... | Yes / No |
| Because of pain..... | Yes / No | Earaches or pain in front of your ears..... | Yes / No |
| Gums bleed easily..... | Yes / No | Jaw symptoms or headaches when you awaken..... | Yes / No |
| Gums bleed when you floss..... | Yes / No | Jaw pain or discomfort affects your appetite, sleep, | |
| Gums feel swollen or tender..... | Yes / No | daily routine or other activities..... | Yes / No |
| Small healing sores in/about your mouth..... | Yes / No | Jaw pain or discomfort is extremely frustrating or | |
| Sensitive teeth..... | Yes / No | depressing..... | Yes / No |
| <i>Feel twinges of pain when your teeth contact:</i> | | Take medications for pain or discomfort (pain relievers, | |
| Hot foods/liquids..... | Yes / No | muscle relaxants, antidepressants)..... | Yes / No |
| Cold foods/liquids..... | Yes / No | Have a temporomandibular (Jaw) disorder (TMD)..... | Yes / No |
| Sours..... | Yes / No | Pain in face, cheeks, jaws, joints, throat or temple..... | Yes / No |
| Sweets..... | Yes / No | Unable to open mouth as far as you'd like..... | Yes / No |
| Dissatisfied with your teeth..... | Yes / No | Aware of an uncomfortable bite..... | Yes / No |
| Prefer to save your teeth..... | Yes / No | Had a blow (trauma) to the jaw..... | Yes / No |
| | | Habitual gum chewer..... | Yes / No |
| | | History of tobacco use..... | Yes / No |



New Patient Medical Health 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 dentistry you will receive. Thank you for answering the following questions.

General

Your medical doctor's name _____ Phone _____

Are you under your physician's care now?..... **Yes / No** If yes, please explain _____

Have you ever been hospitalized or had a major operation? **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 take, or have you taken, Phen-Fen or Redux?..... **Yes / No** If yes, please explain _____

Are you on a special diet?..... **Yes / No** If yes, please explain _____

Do you use tobacco?..... **Yes / No** If yes, please explain _____

Do you use controlled substances?..... **Yes / No** If yes, please explain _____

Women

Are you pregnant or trying to get pregnant? **Yes / No** Are you taking oral contraceptives? **Yes / No** Are you nursing? **Yes / No**

Are you allergic to any of the following?

- Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

If yes, please explain _____

Do you have, or have you had, any of the following?

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

Have you ever had a serious illness not listed above?..... **Yes / No** If yes, please explain _____

Comments: _____

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

Signature of Patient, Parent or Guardian _____ Date _____



Financial Information

Thank you for choosing Espresso Dental. Our primary goal is to provide optimal treatment for an affordable cost. For all routine care and procedures, we are happy to handle the payment paperwork with your dental insurance carrier. For any charges not covered by insurance, payment is due at the time of treatment. We accept cash, checks, and most major credit cards. We can also offer finance plans through ChaseHealthAdvance.

As a courtesy to you, the Espresso Dental staff will gladly assist you in verifying your dental insurance coverage and filing necessary forms, so that you receive all the benefits to which you are entitled. To ensure that we can do so on your behalf, please fill out the information below completely and accurately, and sign on the appropriate line.

Please note that our cancellation policy asks that you provide us at least two business days notice for any necessary appointment cancellations, or you may incur a \$60.00 cancellation fee.

Patient Insurance Information

Patient Name _____ Relationship to Policy Holder _____

Date of Birth _____ Social Security Number _____

Primary Dental Insurance

Policy Holder Name _____ Employer _____

Policy Holder DOB _____ Policy Holder SS# _____

Insurance Company _____

Group # _____ ID # _____ Phone # _____

Secondary Dental Insurance

Policy Holder Name _____ Employer _____

Policy Holder DOB _____ Policy Holder SS# _____

Insurance Company _____

Group # _____ ID # _____ Phone # _____

- I authorize and request my insurance company to pay directly to Dr. Manuel. I understand that there is no guarantee of insurance coverage or payment and that my dental insurance carrier may deny payment or pay less than the actual bill for services. I agree to be responsible for payment for all services rendered on my behalf or my dependents' behalf.

Signature of Patient, Parent or Guardian _____ Date _____

- I do not have dental insurance at this time.

Signature of Patient, Parent or Guardian _____ Date _____

Treatment Consent

- I am seeking treatment for dental-related concerns, and I understand that I will be given treatment choices. I understand that dental procedures may have occasional side effects including, but not limited to, lingering discomfort, infection, or paraesthesia (numbness from local anesthesia). I understand that I can ask questions for more information.

Signature of Patient, Parent or Guardian _____ Date _____



Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Espresso Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Espresso Dental reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

- Any member of my immediate family..... **Yes / No**
- My spouse only..... **Yes / No**
- Other (please specify)..... **Yes / No**

Name of Patient or Personal Representative _____

Description of Personal Representative's Authority _____

Signature of Patient or Personal Representative _____ Date _____



Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Health Care Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our dental care operations. Your personal health information will never be otherwise given to anyone, even family members, without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose. Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental practice operations, and comply with the law. This may include your name, address, telephone numbers, social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Patient Rights

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.