ACCOUNT REGISTRATION

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following forms. If you have any question, don't hesitate to ask.

Please Print Date: _____

Referral Information

How did you first hear about our office? Yellow Pages ☐ Internet/Website ☐ Referred ☐ Drive-By ☐
Insurance Listing ☐ Other _____

If referred, whom may we thank for referring you? _____

Patient Information

Name: _____
(Last) (First) (M.I.) (Nickname)

Home Address: _____ Apt #: _____

City, State, Zip: _____ Cell/Home #: _____

Date of Birth: _____ Sex M ☐ F ☐ Single ☐ Married ☐ Div. ☐ Widowed ☐

Employer or Name of Business: _____

Employer's Address: _____

Occupation: _____ Work Tel #: _____

Email: _____ Social Security #: _____

Spouse Information

(Parent/Guardian or Person Responsible for Account)

Name: _____
(Last) (First) (M.I.) (Nickname)

Address (if different from above): _____ Apt #: _____

City, State, Zip: _____ Cell/Home #: _____

Date of Birth: _____ Sex M ☐ F ☐ Single ☐ Married ☐ Div. ☐ Widowed ☐

Employer or Name of Business: _____

Employer's Address: _____

Occupation: _____ Work Tel #: _____

Email: _____ Social Security #: _____

Dependent Information

Name: _____

Sex: M ☐ F ☐ Date of Birth _____ Lives With: Father _____ Mother _____

Name: _____

Sex: M ☐ F ☐ Date of Birth _____ Lives With: Father _____ Mother _____

Name: _____

Sex: M ☐ F ☐ Date of Birth _____ Lives With: Father _____ Mother _____

LYNNWOOD FAMILY DENTISTRY

Patient Name: _____ Today's Date: _____

Date of Birth: _____ Age: _____

In case of emergency, notify: _____ Relationship to you: _____
(Name & Phone #)

Confidential Medical Health History

Physician: _____ Date of last physical Exam: _____
(Name & Phone #)

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

- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Artificial Heart Valve
- ☐ High Blood Pressure
- ☐ Rheumatic/Scarlet fever
- ☐ Stroke
- ☐ Prolonged Bleeding
- ☐ Pacemaker
- ☐ Lung Problems
- ☐ Tuberculosis
- ☐ Sinus Problems
- ☐ Allergies
- ☐ Stomach Problems
- ☐ Intestinal Problems
- ☐ Prosthetic Joint(s)
- ☐ Diabetes
- ☐ Hepatitis
- ☐ Thyroid Problems
- ☐ Kidney Problems
- ☐ Bladder Problems
- ☐ Seizures/Epilepsy
- ☐ Cancer / Tumor
- ☐ Counseling for stress / Anxiety / depression
- ☐ HIV Positive / AIDS
- ☐ Herpes
- ☐ Sexually Trans. Disease
- ☐ Alcoholism/Drug Abuse
- ☐ Glaucoma
- ☐ Other

List any MEDICATIONS you are currently taking: _____

_____

Are you ALLERGIC to any medication and/or latex gloves? _____

Do you have or have you had any illness or problem not listed above that we should know about? _____

_____

_____

Women: Are you pregnant? _____ If yes, which trimester? _____

Are you taking contraceptives or hormones? _____

Dental Health History

Previous Dentist: _____ Date of last dental visit: _____
(Name & Phone #)

Do you have or do you use any of the following?

- ☐ Teeth sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Swelling or lumps of mouth
- ☐ Bad breath/Unpleasant taste
- ☐ Oral habits, i.e. fingernail biting, cheek biting, etc
- ☐ Unfavorable dental experience
- ☐ Complications from extraction
- ☐ Orthodontic treatment
- ☐ Frequent blisters on lips or mouth
- ☐ Chewing Tobacco
- ☐ Smoking cigarette/cigar/pipe
- ☐ Periodontal treatment
- ☐ Mouth breathing
- ☐ Problems with TMJ

How often do you brush your teeth? _____ Floss? _____

I here by certify that the above information is true and correct to the best of my knowledge.

Signed: _____ Date: _____

INSURANCE INFORMATION

Primary Carrier Information	Secondary Carrier Information
Name of Insured:_____ SSN of Insured: _____ Patient's relationship to the insure: (circle) Self ☐ Spouse ☐ Dependent ☐ Insurance Company Name: _____ Phone #: _____ Group #: _____ Policy #: _____	Name of Insured:_____ SSN of Insured: _____ Patient's relationship to the insure: (circle) Self ☐ Spouse ☐ Dependent ☐ Insurance Company Name: _____ Phone #: _____ Group #: _____ Policy #: _____

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said in accordance with its credit terms and policy. Also, I consent to the taking of photographs and x-rays before, during and after treatment.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: _____ Date: _____

Accident Information

Date of Accident/Injury: _____ Place and time of Accident/Injury_____

Name of Responsible Insurance Company:

_____

Address, City, State, Zip (Insurance):

_____

Telephone #: _____ Policy holder name: _____

Claim #:_____ Attorney name: _____

Address, City, State, Zip (Attorney):

_____

Telephone #: _____ Other pertinent data: _____

_____

_____

LYNNWOOD FAMILY DENTISTRY
FINANCIAL POLICY AND AGREEMENT

Welcome to Lynnwood Family Dentistry. We hope your visits will be pleasant and relaxing. We have found that a clear understanding of our financial policies relieve some of the anxiety associated with going to the dentist. For Your convenience we offer several different payment plans as explained below.

CASH OR CHECK

For patients who have no insurance, we ask that you pay for your dental services at the end of each appointment. This entitles you to a 5% cash discount. If you are a senior citizen (65 years+) please ask about our special courtesy just for you.

VISA OR MASTER CARD

We are happy to accept these credit cards for payment at the end of each appointment. However, none of our discounts apply when using credit cards.

DENTAL INSURANCE

We honor most dental insurance plans and will assist in processing all claims that are assigned. At the end of each visit, please pay **your portion** for any treatment rendered. We do provide estimates for services, but they are only estimates. The final balance and settling of your account won't be known until your insurance claim is paid.

Note: You, not your insurance company, are financially responsible for the entire dental bill, including any balance due after your insurance company has paid its portion.

WE WOULD ALSO LIKE YOU TO KNOW

For all procedures requiring laboratory work, payment must be made at the end of each appointment to cover laboratory expenses.

Our office requires a minimum of **48 business hours notice** (preferably, longer if possible) if you cannot make your appointment. Please remember we are closed on Friday and do not count to our business hours. A **$40.00** per hour charge will be assessed for two successive appointment cancellations without proper notification.

We reserve the right to run random credit reports on accounts.

Monthly payment plans are available on large treatment plans. Financial arrangement must be made prior to your first treatment appointment. Interest will be added to unpaid balance over 30 days at the rate of 1.5% per month (18% per year).

I, the undersigned, acknowledge that I am financially responsible for all fees whether or not paid by insurance. In the event of default of any amount due, and if the account is submitted to collection agency, I agree to pay all collection costs including reasonable attorney fees.

Signature: _____ Date: _____

Lynnwood Family Dentistry
19514 64th Ave W Suite A
Lynnwood, WA 98036
425-771-0165

NOTICE OF PRIVACY PRACTICES – ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____	_____
Patient or legally authorized individual signature	Date
_____	_____
Printed Name	Relationship to Patient

This form will be retained in your medical record.