DUNGENESS DENTAL
B.Travis Johnson, D.D.S

321 N Sequim Ave Suite C
SEQUIM, WA 98382
Phone: (360) 683-4850
Fax: (360) 681-3966

Date:

PATIENT INFORMATION

Name: ☐ Mr ☐ Mrs ☐ Ms ☐ Miss

First Name: _____ Last Name: _____

Birth Date: _____

Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Not Specify

SSN: _____

Driver License: _____

Address: _____ Apt#: _____

City: _____ State: _____ ZIP*: _____

Home: _____

Mobile: _____ Carrier: _____

Email: _____

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DENTAL INSURANCE INFORMATION

Primary Dental Insurance

Subscriber Name:

First Name: _____

Last name: _____

Subscriber D.O.B: _____

Subscriber ID: _____

Medicaid#: _____

Subscriber Address:

_____

City: _____

State: _____

Zip: _____

Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer: _____

Insurer: _____

Insurer Phone: _____

Group Plan: _____

Group#: _____

Secondary Dental Insurance

Subscriber Name:

First Name: _____

Last name: _____

Subscriber D.O.B: _____

Subscriber ID: _____

Medicaid#: _____

Subscriber Address:

_____

City: _____

State: _____

Zip: _____

Relation to Subscriber: ☐ Self ☐ Child ☐ Spouse ☐ Other

Employer: _____

Insurer: _____

Insurer Phone: _____

Group Plan: _____

Group#: _____

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Date:

Health History

Name _____

Name of your physician? _____

Date of last dental/dental hygiene visit? _____

Medical History

1. Are you under medical treatment now? ☐ Yes ☐ No
2. Have you ever been hospitalized for any surgical operation or serious illness? ☐ Yes ☐ No
3. Are you taking any medication(s) including non-prescription medicine? ☐ Yes ☐ No

If yes, what medication(s) are you taking?
cTram remove

4. Do you use tobacco? ☐ Yes ☐ No
5. Do you use alcohol? ☐ Yes ☐ No
6. Do you use cocaine or other drugs? ☐ Yes ☐ No
7. Are you wearing contact lenses? ☐ Yes ☐ No
8. Are you allergic to or have you had any reactions to the following?

Aspirin	☐ Yes ☐ No	Penicillin or other antibiotics	☐ Yes ☐ No
Barbiturates	☐ Yes ☐ No	Sedatives	☐ Yes ☐ No
Iodine	☐ Yes ☐ No	Sulfa drugs	☐ Yes ☐ No
Local anesthetics (e.g. Novocain)	☐ Yes ☐ No		

9. Women only:
   a. Are you pregnant or think you may be pregnant? ☐ Yes ☐ No
   b. Are you nursing? ☐ Yes ☐ No
   c. Are you taking birth control pills? ☐ Yes ☐ No
10. Do you have or have you had any of the following?

AIDS or HIV infection	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No

Angina	☐ Yes	☐ No	Kidney diseases	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Joint replacement or implant	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Cardiac pacemaker	☐ Yes	☐ No	Low blood pressure	☐ Yes	☐ No
Chest pain	☐ Yes	☐ No	Radiation therapy	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Recent weight loss	☐ Yes	☐ No
Easily winded	☐ Yes	☐ No	Respiratory problems	☐ Yes	☐ No
Emphysema	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Epilepsy/Convulsions	☐ Yes	☐ No	Sexually transmitted diseases	☐ Yes	☐ No
Glaucoma	☐ Yes	☐ No	Stomach troubles/Ulcers	☐ Yes	☐ No
Hay fever/Allergies	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Heart attack	☐ Yes	☐ No	Swollen ankles	☐ Yes	☐ No
Heart diseases	☐ Yes	☐ No	Thyroid problem	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No
Heart trouble	☐ Yes	☐ No	Other		
Hepatitis/Jaundice	☐ Yes	☐ No			

Dental History

1. Do your gums bleed while brushing or flossing?	☐ Yes	☐ No
2. Are your teeth sensitive to hot or cold liquid/food?	☐ Yes	☐ No
3. Are your teeth sensitive to sweet or sour liquid/food?	☐ Yes	☐ No
4. Do you feel pain to any of your teeth?	☐ Yes	☐ No
5. Do you have any sores or lumps in or near your mouth?	☐ Yes	☐ No
6. Have you had any head, neck or jaw injuries?	☐ Yes	☐ No
7. Have you ever experienced any of the following problems in your jaw?		

a. Clicking?	☐ Yes	☐ No	c. Difficulty in opening or closing?	☐ Yes	☐ No
b. Pain (joint, ear, side of face)?	☐ Yes	☐ No	d. Difficulty chewing?	☐ Yes	☐ No

8. Do you have frequent headaches?	☐ Yes	☐ No
9. Do you clench or grind your teeth?	☐ Yes	☐ No
10. Do you bite your lips or cheeks frequently?	☐ Yes	☐ No
11. Have you had any difficult extractions in the past?	☐ Yes	☐ No

12. Have you had any orthodontic work? ☐ Yes ☐ No

13. Have you had any prolonged bleeding following extractions? ☐ Yes ☐ No

14. Have you ever had instruction on the correct method of brushing your teeth? ☐ Yes ☐ No

15. Have you ever had instructions on the care of your gums? ☐ Yes ☐ No

Current oral condition

1. How often do you brush your teeth?

2. How often do you floss your teeth?

3. What oral aids do you routinely use at home?

4. Do you want to keep your natural teeth? ☐ Yes ☐ No

5. Do you have complete dentures/partial dentures/fixed bridges/implants? ☐ Yes ☐ No

6. Do you clean your dental appliances? ☐ Yes ☐ No

7. Do you breathe through your mouth? ☐ Yes ☐ No

8. Do you favor one side of your mouth? ☐ Yes ☐ No

9. What you want to change about your oral condition?

I have read my History and confirm that it adequately reflects past and present conditions.

Authorized signature of covered person (For minor, Parent or Guardian) _____

Date: _____

DUNGENESS DENTAL

B. Travis Johnson, D.D.S.

SIGNATURE ON FILE

The undersigned here by authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature authorizes my dentist to submit claims for benefits for services rendered or to be rendered without my signature on every claim submitted for my dependents.

Authorized signature of covered person (For minor, parent or guardian) _____

Print Name _____ Date _____

The undersigned authorizes payment directly to DUNGENESS DENTAL, B. Travis Johnson. D.D.S. otherwise payable to him/her.

Authorized signature of covered person (For minor, parent or guardian) _____

Print Name _____ Date _____

DUNGENESS DENTAL

B. Travis Johnson, D.D.S.

PATIENT FINANCIAL POLICY

Thank you for choosing Dungeness Dental. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of the optimal care as easy and manageable as possible. We will provide you with an estimate of the fees expected.

CANCELLATION AND NO-SHOWS

Our office is designed to give you our personalized care, and as a courtesy, we ask that you give two business days advanced notice if an appointment time change is necessary so that we may give that time to another patient in need. A broken appointment fee of $50.00 or more may be charged to your account for no-shows and failure to give appropriate notice.

FINANCIAL AGREEMENT

All major treatments involving a laboratory procedure will require a down payment. Our office accepts cash, personal checks, and all major credit cards. Outside financing is available through Care Credit upon request and approval. Returned checks will be subject to a $40.00 returned check fee. A finance charge will be applied to all past due accounts.

ASSIGNMENT OF BENEFITS

Our office will accept assignment of benefits from your insurance company with the following provisions:

- We will bill your insurance company as a courtesy with your consent below.
- We require payment for the estimated portion not covered by your insurance company at the time service is provided to you.
- Insurance is typically received within 30 days from the time of billing. If your insurance company has not made payment to our office with the proper time frame, you will be responsible for the entire balance. It will be your responsibility to seek reimbursement from your insurance company.
- We do not guarantee that your insurance company will pay for treatment you receive from our office. We perform routine insurance billing procedures of verification of coverage; however, if your claim is denied, you will be responsible for the full amount.
- We will not enter into a dispute with your insurance company over any claim, although we will provide the necessary documentation if your insurance company requests to support the claim. It will be your responsibility to resolve any dispute over payments or obligations by your insurance company.

I have read and accept the terms and conditions of the policy as defined above.

Print Name _____

Signature_____ Date _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dungeness 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 duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in this facility.

Dungeness 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 or otherwise transmitted 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 healthcare information to the person(s) identified below. I understand that the default answer is "NO." Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.

Spouse only ☐ Yes ☐ No

--- OR ---

Any member of my immediate family (i.e. spouse, children, siblings, etc.) ☐ Yes ☐ No

Any member of my extended family (i.e. parents, grandchildren, etc.) ☐ Yes ☐ No

Other _____ ☐ Yes ☐ No

Patient Name _____ **Patient Signature**_____

Patient's Personal Representative_____ **Date** _____

Representative's Signature _____ **Phone Number** _____

FOR OFFICE USE ONLY

Provided prior to treatment? ☐ Yes ☐ No Date Statement Provided _____

Reason for not obtaining patient signature:

☐ Needed more time to review statement

☐ Wanted to consult another person before signing

☐ Physically unable to sign

☐ No reason offered

☐ Other: _____

DUNGENESS DENTAL

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REQUEST TO RELEASE DENTAL RECORDS

I hereby authorize and request _____ to disclose and give copies of any and all records and information concerning the undersigned to Dungeness Dental, including but not limited to dental records (including operative records), diagnosis, dental history, findings and procedures, radiographs, and any other pertinent information pertinent to my dental work.

In consideration of such disclosure on the part of the above named person or institution, I hereby release them from any and all liability arising from such disclosure.

Patient Name _____

Patient/Guardian Signature _____ Date _____

Office of Previous Dentist_____

Address_____

Phone _____ Fax _____

Email_____

TO BE COMPLETED BY PREVIOUS DENTIST

Date of last visit to your office _____

Date of last prophy_____ Or PMT _____

Date of last complete full mouth X-rays/Pano _____

Perio Charting_____

Please provide copies of perio charting, and proposed treatment, and most current x-rays. Please email x-rays to info@dungenessdental.com.

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