Welcome

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us - we will be happy to help.

Patient # _____

SS#/SIN _____

Date _____

Patient Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Email _____ Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

If Student, Name of School/College _____ City _____ State/Prov. _____ ☐ Full Time ☐ Part Time

Patient or Parent/Guardian's Employer _____ Work Phone _____

Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Whom may we thank for referring you? _____

Person to contact in case of emergency _____ Phone _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this person currently a patient in our office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ I wish to discuss the office's payment policy.

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State/Prov. _____ Zip/P.C. _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

How much is your deductible? _____ How much have you used? _____ Max. annual benefit _____

Over Please

Patient Medical History

Physician _____ Office Phone _____ Date of Last Exam _____

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.

	Yes	No
1. Are you under a physician's care now?	☐	☐
If yes, please explain _____		
2. Have you ever been hospitalized or had a major operation?	☐	☐
If yes, please explain _____		
3. Have you ever had a serious head or neck injury?	☐	☐
4. Are you taking any medications, pills, or drugs?	☐	☐
Please list _____		
5. Do you take, or have you taken, Phen-Fen or Redux?	☐	☐
6. Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	☐	☐
7. Are you on a special diet?	☐	☐
8. Do you use tobacco?	☐	☐

10. Are you allergic to any of the following?	Yes	No
Aspirin	☐	☐
Penicillin	☐	☐
Codeine	☐	☐
Acrylic	☐	☐
Metal	☐	☐
Latex	☐	☐
Sulfa drugs	☐	☐
Local Anesthetics	☐	☐
Other? If yes _____	☐	☐
Do you use controlled substances? If yes _____	☐	☐
11. Women: Are you...		
Pregnant/Trying to get pregnant?	☐	☐
Nursing	☐	☐
Taking oral contraceptives?	☐	☐

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

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

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Are your teeth sensitive to sweet or sour liquids/foods?	☐	☐
4. Do you feel pain to any of your teeth?	☐	☐
5. Do you have any sores or lumps in or near your mouth?	☐	☐
6. Have you had any head, neck or jaw injuries?	☐	☐
7. Have you ever experienced any of the following problems in your jaw?		
Clicking	☐	☐
Pain (joint, ear, side of face)	☐	☐
Difficulty in opening or closing	☐	☐
Difficulty in chewing	☐	☐

	Yes	No
8. Do you have frequent headaches?	☐	☐
9. Do you clench or grind your teeth?	☐	☐
10. Do you bite your lips or cheeks frequently?	☐	☐
11. Have you ever had any difficult extractions in the past?	☐	☐
12. Have you ever had any prolonged bleeding following extractions?	☐	☐
13. Have you had any orthodontic treatment?	☐	☐
14. Do you wear dentures or partials?	☐	☐
If yes, date of placement _____		
15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	☐	☐
16. Do you like your smile?	☐	☐

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor) Date

Doctor's Comments _____

_____

_____ Signature _____ Date _____

Wine Country
FAMILY DENTAL

Broken Appointment / Cancellation Policy

Welcome to Wine Country Family Dental! We respect your time and would like to make your visit to our office as efficient as possible. We are very excited to provide you and your family with outstanding dental care.

About our Broken Appointment / Cancellation Policy

If you fail to show for a scheduled appointment, all future appointments you may have scheduled will be cancelled. We ask that you please notify us as early as possible if you are unable to keep your appointment. ***A fee of $50.00 may be charged for any appointment broken or cancelled with less than 24 hours notice.***

I have read and understand Wine Country Family Dental's broken appointment policy.

Patient Signature: _____ Date: _____
(*Signature of parent/legal guardian if patient under 18yrs old)*

Print Name: _____

*********Please Circle the best way to confirm your appointments**********

Home Phone Work Phone Cellular Text Message or Email

Please provide us that number or email: _____

List Child (ren) Name: _____

_____

_____

_____

Wine Country Family Dental
Patient Policies Form

In-House Payment Plans

We will need **2 current paystubs** from the patient. A down payment will be required at start of actual treatment; anywhere from $250 **and up**, depending on treatment being performed. *(We only allow up to 9 months Interest Free in our office, we will let you know how many months will be allowed once we know what needs to be done)*

You will also need to have a current debit or credit card; your monthly payments will be automatically processed on the day that you choose. (days to choose from are the 1st, 5th, 10th, 15th, 20th or 25th)

**if during the duration of your payments, you should lose your card on file or should it expire, it is your responsibility to call or come in to our office to update your information*.*

This is a great option for a lot of our patients! **Please be aware that if a payment is denied and you haven't given us prior notice as to why a payment may not be made on time, could potentially eliminate you from being offered a payment plan within our office in the future.

_____ Patient Initials

Insurance Policy

We will submit a claim to your insurance for any procedures as a courtesy for our patients. We will also call your insurance to get a basic breakdown, but ultimately you are fully responsible for the cost of treatment, if the insurance company doesn't make payment, for any reason.

Reasons why insurance could possibly deny the claim could be: terminated plan, not a covered benefit, not a covered code, age limits, missing tooth clause, coordination of benefits or for any other reason

It is your responsibility to know your plan policy.

We are also more than happy to send a pre-determination to your insurance to make sure it is a benefit, and how much they will pay (you will need to allow 2-4 weeks for pre-authorizations to be approved or denied)

_____ Patient Initials

Cell Phones are **not allowed** during your treatment appointment, we ask that you please put them on "silent" and in your purse or off to the side while Dr Schutte is in the operatory room with you. There are many sharp, small instruments and your safety is our number one concern. The assistant can hand your cell phone right back to you as soon as your treatment is completed. _____ Patient Initials

CareCredit

We offer Care Credit here! We can help you fill out the application and process it; it only takes 5 minutes to get approved. Once approved, and depending on how much you will need to use; they allow us to process 6months, 12months, 18 months or up to 24 months Interest Free payments!!

Patient/Guardian Signature: _____ Date: _____

The Epworth Sleepiness Scale

The Epworth Sleepiness Scale is widely used in the field of sleep medicine as a subjective measure of a patient's sleepiness. The test is a list of eight situations in which you rate your tendency to become sleepy on a scale of 0, no chance of dozing, to 3, high chance of dozing. When you finish the test, add up the values of your responses. Your total score is based on a scale of 0 to 24. The scale estimates whether you are experiencing excessive sleepiness that possibly requires medical attention.

How Sleepy Are You?

How likely are you to doze off or fall asleep in the following situations? You should rate your chances of dozing off, not just feeling tired. Even if you have not done some of these things recently try to determine how they would have affected you. For each situation, decide whether or not you would have:

- No chance of dozing = 0
- Slight chance of dozing = 1
- Moderate chance of dozing = 2
- High chance of dozing = 3

Write down the number corresponding to your choice in the right hand column. Total your score below.

Situation	**Chance of Dozing**
Sitting and Reading	*
Watching TV	*
Sitting inactive in a public place (e.g., a theater or a meeting)	*
As a passenger in a car for an hour without a break	*
Lying down to rest in the afternoon when circumstances permit	*
Sitting and talking to someone	*
Sitting quietly after a lunch without alcohol	*
In a car, while stopped for a few minutes in traffic	*

Total Score = _____

Analyze Your Score

Interpretation:

0-7: It is unlikely that you are abnormally sleepy.

8-9: You have an average amount of daytime sleepiness

10-15: You may be excessively sleepy depending on the situation. You may want to consider seeking medical attention.

16-24: You are excessively sleepy and should consider seeking medical attention.

Reference: Johns MW. A new method for measuring daytime sleepiness: The Epworth Sleepiness Scale. *Sleep* 1991; 14(6):540-5

Patient Name: _____ **Chart #:** _____ **Date:** _____

Wine Country
FAMILY DENTAL

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 Manager.

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 if signed on behalf of the patient Relationship
(Parent, Legal Guardian, Etc.)

Please list individual(s) allowed to call, discuss, or confirm my dental appointment and or records:

_____
Print Name(s)

_____
Relationship (Spouse, Parent, Sibling)

☐ I don't want to share Any information with anyone, other than myself. _____
Initials

☐ I choose not to take my copy of the privacy policy _____
Initials

STATEMENT OF PRIVACY PRACTICES

WINE COUNTRY FAMILY DENTAL

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principle concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR HEALTHCARE 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 health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. 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, integrity, and access to 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 HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

YOUR RIGHTS AS OUR PATIENT

You have a 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. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

WINE COUNTRY FAMILY DENTAL
6225 BURDEN BLVD. PASCO, WASHINGTON 99301 / (509) 547-3000

PLEASE LET THE FRONT OFFICE RECEPTIONIST KNOW IF YOU WOULD LIKE A PRINTED COPY FOR YOUR RECORDS