

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 Information (CONFIDENTIAL)

Name _____ Birthdate _____ Home Phone _____
Address _____ City _____ State _____ Zip _____
Email _____ Cell Phone _____

Check Appropriate Box: Child Single Married Divorced Widowed Separated

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

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

Address _____ City _____ State _____ Zip _____

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 (if under 18 yrs. old) _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____

Employer _____ Work Phone _____ Social Security # _____

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 Care Credit Other I wish to discuss the office's payment policy.

Insurance Information

Name of Subscriber _____ Relationship to Patient _____

Birthdate _____ SS# or ID# _____

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

Insurance Company Name _____ Group # _____ Member # _____

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

Name of Subscriber _____ Relationship to Patient _____

Birthdate _____ SS# or ID# _____

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

Insurance Company Name _____ Group # _____ Member # _____

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.

- | | | | |
|---|--|--|--|
| 1. Are you under a physician's care now?.....
If yes, please explain. _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | 10. Are you allergic to any of the following? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Have you ever been hospitalized or had a major operation?....
If yes, please explain. _____ | Yes <input type="checkbox"/> No <input type="checkbox"/> | Aspirin..... | <input type="checkbox"/> <input type="checkbox"/> |
| 3. Have you ever had a serious head or neck injury? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Penicillin..... | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Are you taking any medications, pills, or drugs? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Codeine..... | <input type="checkbox"/> <input type="checkbox"/> |
| Please list _____ | | Acrylic..... | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Do you take, or have you taken, Phen-Fen or Redux?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | Metal..... | <input type="checkbox"/> <input type="checkbox"/> |
| 6. Have you ever taken Fosamax, Boniva, Actonel or | Yes <input type="checkbox"/> No <input type="checkbox"/> | Latex..... | <input type="checkbox"/> <input type="checkbox"/> |
| any other medications containing bisphosphonates? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Sulfa drugs..... | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Are you on a special diet? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Local Anesthetics..... | <input type="checkbox"/> <input type="checkbox"/> |
| 8. Do you use tobacco? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Other? If yes _____ | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Do you have or have you had, any of the following? | | Do you use controlled substances? If yes _____ | <input type="checkbox"/> <input type="checkbox"/> |

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

Patient Dental History

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

- | | | | |
|---|--|--|--|
| 1. Do you like your smile and if not, what do you want to change if you could?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | 6. Have you ever had a "Deep Cleaning" where you have to use local anesthetic, or be "Numbed"?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Do you have any pain, sensitivity or bleeding of your teeth or mouth? | Yes <input type="checkbox"/> No <input type="checkbox"/> | 7. Do you snore, or frequently wake up at night or have you ever been told you have Sleep Apnea?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Do you ever clench or grind your teeth, do you have frequent headaches, clicking, popping, or pain in the jaw joint? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Explain:..... | |
| (Circle all that apply) | | 8. How would you rate the condition of your mouth? | |
| 4. Have you ever had orthodontic treatment (braces or clear aligner therapy like Invisalign?)..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor | |
| 5. Are you interested in Braces or Invisalign?..... | Yes <input type="checkbox"/> No <input type="checkbox"/> | 9. What is your most important/urgent concern? | |
| | | _____ | |
| | | _____ | |

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 child) _____ Date _____

Initials of receptionist that reviewed patient paperwork _____ 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

Payment plan options: Sunbit or Care Credit

Sunbit Financing

You will need: a copy of your Drivers License or State ID, Email address & Debit Card. Sunbit is very easy to apply for and has a low monthly payment plan option. Sunbit will run a soft credit check (so doesn't show up on your credit reports when applying for it). You will make a monthly payment with a **debit card only** to Sunbit directly. (see in office pamphlets for more information)

_____ **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 6 months, 12 months, 18 months or up to 24 months with Interest Free payments!! *(side note: make sure you pay off the balance owed before the promotional interest free time is up, otherwise you will be charged interest from the 1st day you processed the transaction)*

_____ **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**

Patient/Guardian Name: _____ 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:** _____

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.

SUD Treatment Information. If we receive or maintain any information about you from a substance use disorder treatment program that is covered by 42 CFR Part 2 (a “Part 2 program”) through a general consent you provide to the Part 2 Program to use and disclose the Part 2 Program record for purpose of treatment, payment or health care operations, we may use and disclose your Part 2 Program record for treatment, payment and health care operations purposes as described in this Notice. If we receive or maintain your Part 2 Program record through specific consent you provide to us or another third party, we will use and disclose your Part 2 Program record only as expressly permitted by you in your consent as provided to us.

In no event will we use or disclose your Part 2 Program record, or testimony that describes the information contained in your Part 2 Program record, in any civil, criminal, administrative, or legislative proceedings by any Federal, State, or local authority, against you, unless authorized by your consent or the order of a court after it provides you notice of the court order.

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**

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