HEALTH HISTORY

Patient's Name	Home Phone	Work Phone	Cell Phone

Address	City	Zip	Email Address

Birth Date _____/_____/_____

Place of Employment & Department _____

1. Have you had a serious illness or operation within the last 2 years?..... Yes No
   If so, please explain_____
2. Are you currently under a doctor's care?..... Yes No
   If so, please explain_____
3. Have you been hospitalized during the last 2 years?..... Yes No
   If so, please explain_____
4. Are you limited in activity because of a physical or medical condition?..... Yes No
5. Are you presently under excessive emotional, mental or occupational stress?..... Yes No
6. Are you currently taking **ANY** medications, pills, drugs or syrups?..... Yes No
   If so, please list them_____
7. Do you bleed excessively when cut or during a tooth extraction?..... Yes No
8. Have you had any serious troubles associated with previous dental treatment or dental anesthetic? Yes No
9. Are you **ALLERGIC** to (Please circle):
   ANTIBIOTICS PENICILLIN CODEINE PAIN PILLS LATEX RUBBER JEWELERY METALS
   List any other allergies_____
10. Is there any other disease, condition, problem that may affect the success of your dental treatment? Yes No
11. Have you **EVER** taken any diet medications past/present?..... Yes No
12. Do you have high cholesterol? ..... Yes No
13. Do you smoke or chew tobacco products?..... Yes No
14. Do you consume more than 2 alcoholic drinks per day? ..... Yes No
15. Have you had any other serious conditions/illnesses not listed above/below?..... Yes No
    If YES, please list_____
16. Do you have or have you **EVER** had any of the following: ☐ **None Below**

- ❑ Abnormal Blood Pressure
- ❑ AIDS
- ❑ Anemia
- ❑ Angina/Chest Pain
- ❑ Arthritis
- ❑ Artificial Hip/Limb Pin/Joint/Plate
- ❑ Asthma
- ❑ Bacterial Endocarditis
- ❑ Breathing Problems
- ❑ Cancer/Tumors
- ❑ Chemo-Therapy
- ❑ Congenital Heart Problem
- ❑ Diabetes
- ❑ Epilepsy/Seizures
- ❑ Eyeglasses/Contacts
- ❑ Fainting Spells
- ❑ Frequent Headaches
- ❑ Glaucoma
- ❑ Hearing Aid
- ❑ Heart Valve Replacement
- ❑ Heart Murmur
- ❑ Heart Trouble
- ❑ Heart Surgery
- ❑ Hepatitis A (Infectious)
- ❑ Hepatitis B (Serum)
- ❑ Hepatitis C
- ❑ HIV Positive
- ❑ Kidney Trouble
- ❑ Mitral Valve Prolapse
- ❑ Nervousness
- ❑ Pacemaker
- ❑ Psychiatric Care
- ❑ Radiation Therapy
- ❑ Recreational Drugs
- ❑ Recovering Alcohol/Drug Abuser
- ❑ Rheumatic Fever
- ❑ Sexually Transmitted Disease
- ❑ Sinus Trouble/Sinusitis
- ❑ Stroke
- ❑ Substance Addiction
- ❑ Swelling of Ankles
- ❑ Tuberculosis
- ❑ Ulcers/Colitis
- ❑ Other _____

Women: Do you take birth control pills?..... Yes No
Are you pregnant? (If maybe circle yes) Delivery date? ..... Yes No
Are you nursing?..... Yes No

I, the undersigned (patient or legally responsible party) certify that the information given on this form is true and correct, authorize dental diagnosis and treatment to be performed by Dr. Mar/Staff and assume financial responsibility for dental services.

Signature _____ Date _____

☐ Adult Patient ☐ Father/Husband ☐ Mother/Wife ☐ Guardian

PATIENT DENTAL HISTORY

Name_____ Date_____

1. What is your present dental concern? _____ Services Desired_____
2. Please describe your general dental health_____
3. How long since your last dental visit? _____ Former Dentist _____
   NAME CITY STATE
4. How long since your last cleaning visit?_____
5. Have you had a complete set of dental x-rays (about 16 films), taken within the last two years? YES NO
6. Do you think you have active decay or gum disease? _____ YES NO
7. Are you worried about receiving dental treatment? _____ YES NO
8. Have you ever had an unusual reaction or problem with dental anesthetic or treatment? _____ YES NO
9. How often do you brush_____Brush Type: ☐ SOFT ☐ MED ☐ HARD. Do you use fluoride toothpaste? YES NO
10. How often do you floss_____ What other oral homecare products/devices do you use? _____
    _____
11. Has plaque removal between teeth, and above and below the gumline been emphasized and demonstrated to you with brush, floss, stimudents or other devices? _____ YES NO
12. Is there anything you would change about the appearance of your teeth? _____ YES NO
13. Are you missing any teeth?_____ YES NO
    Have they been replaced by bridges, partials, or dentures? _____ YES NO
14. Do your gums bleed while brushing or flossing? _____ YES NO
15. Does food pack between any teeth? _____ YES NO
16. Are any teeth sensitive to hot, cold, sweets, or pressure? _____ YES NO
17. Do you have a regular high sugar consumption habit (pop, hard candy, mints, etc.)? _____ YES NO
18. Do you chew gum or hard objects such as ice, popcorn kernels, etc.? _____ YES NO
19. Do you ever have popping, clicking, or discomfort in your jaw joint (TMJ)? _____ YES NO
20. Are you aware of clenching or grinding your teeth during the day or night?_____ YES NO
21. Do you have frequent headaches?_____ YES NO
22. Do you or have you ever worn a nightguard?_____ YES NO
23. Do you have or have you ever had slow healing sores or growths in your mouth?_____ YES NO
24. Circle any of the following concerns you have about your mouth, teeth, or gums:

Bad Breath	Spaces	Periodontitis	Discolored Fillings
Bad Taste	Infection	Loose Teeth	Smile
Missing Teeth	Swollen Gums	Shifting Teeth	Gag Easily
Broken Teeth	Red Gums	Appearance	Crooked Teeth
Old Fillings	Bleeding Gums	Bad Bite	Other_____
Broken Fillings	Gingivitis	Dark Teeth	

25. How important is it to you to keep your existing natural teeth the rest of your life?_____
26. CHILDREN TO AGE 14 YEARS:
    Is your current drinking water fluoridated?_____ UNKNOWN YES NO
    Is your child taking supplemental fluoride tablets/drops? _____ UNKNOWN YES NO
    In the past, has your child had fluoridated water or supplemental fluoride tablets/drops? UNKNOWN YES NO
    Have your child's permanent molars been sealed?_____ UNKNOWN YES NO
    Does your child have any oral habits such as thumb sucking, lip biting, mouth breathing, tongue thrusting when swallowing, etc.? _____ UNKNOWN YES NO

_____

_____

_____

PLEASE COMPLETE REVERSE SIDE

PATIENT FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before any dental treatment begins. If you have any questions about the dental treatment or payment for services please see the receptionist before accepting treatment.

We accept the following financial plans.

1. **Major Credit Cards**:
   VISA, MasterCard, Discover Card

2. **Patients With Insurance:**
   The estimated balance not covered by insurance is due at time of service.

3. **Patients Without Insurance:**
   Payment for all dental services is due at the time of service.

PATIENT RESPONSIBILITY AGREEMENT

We will submit your claims in a timely fashion to ensure that you receive the coverage allowed under your plan. Since there are many different insurance plans that are available today, it is the patient's responsibility to check with their insurance provider to verify what services are covered. It is the patient's responsibility to negotiate and work directly with their insurance provider on any outstanding or disputed claims.

A finance charge of 1% per month is applied on all account balances after 60 days.

A $50.00 non-sufficient fund fee will be charged for all checks returned from the bank.

Missed appointments or changes to appointments without a 48-hour notice to the office will result in a $50.00 missed appointment fee.

Regardless of insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependants.

I have read and understand the above financial and patient responsibility agreement.

Patient Name (please print) _____

Signature_____ Date_____

*acceptance of credit cards and fees may be subject to change without notice.

Roderick S. Mar, D.D.S. ***3049 Beacon Avenue South Seattle, WA98144***

Welcome to our Dental Office. To ensure that we can provide you with the best dental care possible, please accurately complete this patient registration form. We're please you selected us as your Dental Care Providers.

Dr. Rod and Staff

PATIENT REGISTRATION
(PLEASE PRINT CLEARLY)

Email Address_____ DATE _____

Patients Name _____ Name you prefer to be called _____
LAST FIRST MIDDLE

Home Address _____
& STREET CITY STATE ZIP HOME PHONE

Social Security #_____ Birthdate_____ Age_____ Sex ☐M ☐F

Status: ☐ Minor (under 18 years of age)

If Child, Father's Name _____ Social Security #_____
LAST FIRST MIDDLE

Mother's Name_____ Social Security #_____
LAST FIRST MIDDLE

Name of Spouse_____ Social Security #_____
LAST FIRST MIDDLE

Children in Family (names & ages) _____

Have you ever been a patient of ours? ☐Yes ☐No Has any member of your family ever been a patient of ours? ☐Yes ☐No

Occupation (or school)_____ (grade)_____

Patient/Parent Employed by_____ How Long? _____

Work Address_____ Work Phone_____

Spouse Occupation_____ Employed by_____ How Long? _____

Spouse's Work Address _____Work Phone _____

Person Financially Responsible for Account_____
(NOT IONSURRANCE COMPANY) FULL NAME DRIVERS LICENCE # HOME PHONE

Billing Address _____
& STREET CITY STATE ZIP

Employed by _____
BUSINESS OR COMPANY POSITION HELD HOW LONG? WORK PHONE

Who may we thank for referring you to our office? _____

Should we have a change in schedule, would you like to be called to take an appointment with short notice to expedite your treatment? ☐YES ☐NO

IN CASE OF AN EMERGENCY CONTACT

Nearest friend or relative _____
(not living with you) FULL NAME RELATIONSHIP WORK PHONE HOME PHONE

Address _____
& STREET CITY STATE ZIP

DENTAL INSURANCE INFORMATION

FIRST COVERAGE

Employee Name _____
Employee Date of Birth_____
Employer _____ # Years _____
Name of Ins. Co._____
Ins. Co. Address _____
Ins. Co. Phone # _____
Policy # _____
Employee Social Security # _____

SECOND COVERAGE

Employee Name _____
Employee Date of Birth_____
Employer _____ # Years _____
Name of Ins. Co._____
Ins. Co. Address _____
Ins. Co. Phone #_____
Policy #_____
Employee Social Security # _____

Roderick S. Mar DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I have reviewed a copy of this office's Notice of Privacy Practices.

_____
(Please Print Name)

_____
(Signature)

_____
(Date)

List additional people, if any, approved to have access to patient information:

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)