MOUNTAIN VIEW
DENTAL CENTER
R. Charlie & Ute Collins • Keri Halgren
D.D.S., P.L.L.C.

Patient Information

How did you hear about our office? _____

Dental Health History

Are you apprehensive about dental treatment?	Y ☐	N ☐
Have you ever had any complications following dental treatment?	Y ☐	N ☐
Are you happy with the appearance of your teeth?	Y ☐	N ☐
Do you want your teeth to be whiter?	Y ☐	N ☐

_____
Initial

Medical Health History

Physician Name: _____

Emergency Contact: _____ Phone_____

Do you have any allergies to any medications or latex products? Y ☐ N ☐

If yes, please list: _____

Are you taking any medications or herbal supplements? Y ☐ N ☐

if yes, please list: _____

Do you use tobacco products? _____

Do you have any of the following conditions?

☐ High Blood Pressure	☐ History of Heart Attack or Stroke	☐ Asthma
☐ Diabetes	☐ Rheumatic Heart Fever	☐ Mitral Valve Prolapse
☐ Sleep Apnea	☐ HIV/AIDS	☐ Hepatitis
☐ Snoring	☐ Heart Murmur	☐ Tuberculosis
☐ Heart Disease	☐ Lung Problems	☐ Joint Replacement
☐ Cancer Treatment	☐ Epilepsy or Seizures	☐ Chest Pains
☐ Bleeding Disorder	☐ Thyroid Disorder	☐ Headaches/Migraines
☐ History of Fosamax Treatment (or other osteoporosis medication)		☐ Acid Reflux
☐ Memory Problems		☐ Pregnancy

Do you have any other illness, condition, or problem not listed above? Y ☐ N ☐

If yes, please describe briefly: _____

_____

Blood Pressure_____

*Staff Initials*_____

MOUNTAIN VIEW
DENTAL CENTER
R. Charlie & Ute Collins • Keri Halgren
D.D.S., P.L.L.C.

Acknowledgement and Consent

Health history

I understand that providing incorrect information can be dangerous to my health. I certify that I have read, understood, and completed the health history questionnaire fully and accurately to the best of my ability.

Release of information

I understand that the dentist may need to collaborate with other healthcare providers and/or third-party payors in order to provide the best standard of care for me. I authorize the dentist to release any necessary information, including the diagnosis and the records of any treatment or exam rendered to me or my dependent during the period of dental care to third-party payors and/or other health care providers related to my care.

Financial policies

I understand that this office offers the service of accepting and filing most dental insurance claims for patients. I understand that the office staff, as a courtesy, will research any applicable benefits for me and assist me in understanding my insurance policies. I understand that the dental office will make every effort to give me accurate estimates of what I will owe for each visit, but that they cannot guarantee exactly what my insurance will pay. I understand that if I have dental insurance, this is a contract between the insurance company and myself, and is ultimately my responsibility, not the dental office's responsibility.

I understand that I am expected to pay what is due for my treatment when I receive it. I understand that when a child of divorced parents is seen, whichever parent accompanies the child to their visit will be expected to pay. I understand that if any balance remains after my insurance company has paid a claim, I will receive a statement from the dental office for this, and I am expected to pay in full within 15 days of receiving this statement. A late fee of 18% of total balance or $25.00 (whichever is greater) will be applied to balances over 30 days.

I agree to be responsible for timely payment for all services rendered on my behalf or my dependents. I agree to be ultimately responsible for all charges on my account which have been applied in accordance with established office policy.

I understand that if my account remains unpaid, it may be transferred to a collections agency. If legal action is commenced, the venue will be placed in Skagit County, WA.

I understand that my account will be charged a $50 fee for any dishonored check, and that I am expected to pick up the check and pay the balance and subsequent fees in cash.

I understand that these policies may be superceded by a written and signed agreement of an alternate policy specific to my account.

Rescheduling/cancellation policies

I understand that if I need to reschedule an appointment, or cannot make an appointment, I must give 48 hours notice to a staff member. If I do not give adequate notice, my account will be charged a $50 cancellation fee.

I understand that if I fail or cancel more than 3 consecutive appointments without appropriate notice, my active patient status will be reduced to emergency status, and I will be advised to seek an alternate dental provider.

Privacy Practices

_____ I acknowledge receipt of Privacy Practices Notice (HIPPA).

Initial

Signature of patient *(or parent/guardian if a minor)* *date*

Printed Name of patient *(or parent/guardian if a minor)* *Patient Name (if minor)*

Preferred method of contact for appointment reminder.

☐ *Phone* _____ ☐ *Text* _____ ☐ *e-mail*_____

1220 22nd St., Suite C • Anacortes, WA 98221 • 360.293.5311