mill creek dental
DR. NIKKI CHIN

New Patient Information

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Gender: ____ Age: _____

Preferred name: _____ Date of birth: _____

Home address: _____
Street City State Zip

Billing address: _____
(if different) Street City State Zip

Home phone: _____ Cell: _____

E-mail: _____

SS #: _____ Employer/Occupation: _____

Spouse's name: _____ Phone Number: _____

Who may we thank for referring you? _____

Insurance Information

Primary dental insurance: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Subscriber ID: _____

Secondary dental insurance: _____ Group #: _____

Policy Holder: _____ Date of Birth: _____

Subscriber ID: _____

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Name: _____

Dental History

Y N Are you apprehensive about dental care?
Y N Have you had problems with previous treatment?
Y N Do you gag easily
Y N Do you wear dentures?
Y N Does food catch between your teeth?
Y N Do you have difficulty chewing your food?
Y N Do you avoid brushing any part of your mouth?
Y N Do your gums bleed easily? Feel swollen or tender?
Y N Have you noticed slow-healing sores in your mouth?
Y N Are your teeth sensitive?
Y N Does your mouth feel dry?
Y N Do you feel pain when your teeth come in contact with:
____ Hot foods or liquids
____ Cold foods or liquids
____ Sour foods
____ Sweets

Y N Do you take fluoride supplements?
Y N Are you dissatisfied with the appearance of your teeth?
What do you dislike about your teeth/smile?
_____
Y N Does your jaw make noise that bothers you or others?
Y N Do you clench or grind your jaws frequently?
Y N Does your jaw get stuck so that you can't open freely?
Y N Does it hurt when you chew or open wide to take a bite?
Y N Do you have any jaw symptoms or headaches after waking?
Y N Do you have a temporomandibular (jaw) disorder?
Y N Do you have pain in the face, cheeks, jaws, joints, temples?
Y N Are you aware of an uncomfortable bite?
Y N Have you had a blow to the jaw (trauma)?
Y N Are you a habitual gum chewer?
Y N Have you had orthodontics/braces?
Y N Do you have your wisdom teeth?

Medical History

Do you have or have you had any of the following? (Please check any that apply)

- ❑ Being treated for a medical condition
  Please explain: _____
- ❑ Have/had any serious illness or operation? _____
  _____
  _____
- ❑ Smoke or use chewing tobacco
  _____frequency
- ❑ Recreational drug use: _____
  _____frequency
- ❑ Acid Reflux/GERD
- ❑ Aids/HIV
- ❑ Anxiety
- ❑ Artificial Joints
  Type and When: _____
- ❑ Asthma
- ❑ Blood disease
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Dizziness
- ❑ Eating disorder
- ❑ Epilepsy
- ❑ Excessive Bleeding
- ❑ Fainting
- ❑ Fibromyalgia
- ❑ Glaucoma
- ❑ Hay Fever
- ❑ Head Injuries
- ❑ Heart Disease
- ❑ Heart Murmur
- ❑ Hepatitis
- ❑ High Blood Pressure
- ❑ Jaundice
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Mental Disorders
- ❑ Mitral Valve Prolapse
- ❑ Nervous Disorders
- ❑ Pacemaker
- ❑ Radiation Treatment
- ❑ Respiratory Problems
- ❑ Rheumatic Fever
- ❑ Sleep apnea
  CPAP? Y/N
- ❑ Sinus Problems
- ❑ Stroke
- ❑ Thyroid condition
- ❑ Tuberculosis
- ❑ Tumors
- ❑ Ulcers
- ❑ Venereal Disease

Other: _____

Name: _____

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(Medical History Continued)

Are you allergic to, or have you reacted adversely to any of the following?

- ❑ Latex materials
- ❑ Penicillin or other antibiotics
- ❑ Local anesthetics ("Novocain")
- ❑ Codeine or other narcotics
- ❑ Sulfa drugs
- ❑ Barbiturates, sedatives, or sleeping pills
- ❑ Aspirin/Acetaminophen/Ibuprofen
- ❑ Metals
- ❑ Other:_____

Women:

- ❑ May be pregnant
  Expected delivery date: _____
- ❑ Nursing
- ❑ Taking hormones or contraceptives

Are you taking any of the following?

- ❑ Aspirin
- ❑ Anticoagulants (blood thinners)
- ❑ Antibiotics or sulfa drugs
- ❑ High blood pressure medicine
- ❑ Antidepressants or tranquilizers

  Please list: _____
- ❑ Insulin, Orinase, or other diabetes drug
- ❑ Nitroglycerin
- ❑ Cortisone or other steroids
- ❑ Osteoporosis (bone density) medicine

  Please list: _____
- ❑ Antibiotics prior to dental appointments?
- ❑ Other:_____

Name of your physician: _____ Date of last visit: _____

Do you have any disease, condition, or problem not listed above? _____

_____

Please list all medications (including supplements): _____

_____

_____

Please add anything else you would like us to know about: _____

_____

_____

I have read the above questions and understand them. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist of any changes in my medical or dental health.

Signature of patient (or parent): _____ Date: _____

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Dental Insurance and Financial Arrangements

Payment for services is due at the time services are rendered unless payment arrangements have been approved in advance by our staff.

If you have dental insurance we will work hard to help you receive your maximum allowable benefit. In order to achieve this goal we need you to take the necessary steps to understanding your insurance plan. Being there are so many different providers and plans, it is impossible for us to know all of our patients' benefits. It is very important for you as a dental insurance policy holder, to be aware of the plan benefits, deductibles, and exclusions. Plan benefits can be obtained by calling your dental insurance company. We will gladly discuss your proposed treatment and answer any questions that you may have relating to your insurance. You, however, must be aware that:

1. Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.
2. Most insurance companies have a yearly deductible that is your responsibility to pay.
3. Most insurance companies only pay a percentage of the cost (such as 50% or 80%) and you will be responsible for the remainder.
4. Not all services are a covered benefit in all contracts. It is important for you to contact your insurance provider and ask if there are any clauses, or waiting periods.
5. As a courtesy to you, our office will submit claims to your insurance provider. If for any reason the claims go unpaid you will be responsible for all charges.

If you have any questions regarding this information, or any uncertainty regarding insurance coverage please don't hesitate to ask us, we are here to help you in any way we can.

I _____ am financially responsible for any and all charges on my account.

I have read and understand the above information.

Signature of patient (or parent): _____ Date: _____

I authorize release of any information regarding my dental treatment to my dental and/or medical insurance company.

Signature of patient (or parent): _____ Date: _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been offered a copy of Mill Creek Dental's Notice of Privacy Practices. 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. It also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

☐ No one
☐ Any immediate family member
☐ Spouse only
☐ Other (Please Specify): _____

Patient name (please print): _____

Signature of patient (or parent): _____ Date: _____

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Authorization and Consent to Send Unencrypted Patient Information by Email and Other Electronic Means

Until I tell you in writing to stop, I authorize Mill Creek Dental to transmit patient information relating to my treatment, health, or payment by email or other electronic means, without encryption or special security precautions, to me or someone I designate, or to other health care providers, health plans and others involved in my treatment, payment for my treatment, or Mill Creek Dental's health care operations. The patient information that may be emailed may include my x-rays, health history, diagnosis, treatment, and payment records.

I understand that:

- I do not have to sign this form.
- My treatment, payment, enrollment and eligibility for benefits will not be affected by my decision about signing this form.
- If I don't sign this form, Mill Creek Dental may use other ways to send my information, such as U.S. Mail, or may ask me to send my information to third parties myself.
- There is some risk that emails and other electronic messages may be improperly acquired by hackers or received by unintended recipients. If that happens, the information may be re-disclosed and no longer protected by privacy law.
- Mill Creek Dental does not email such sensitive personal information as Social Security number, credit card number, mental health diagnosis, genetic information, alcohol/substance abuse, or positive HIV status unless the patient insists.

I can tell you in writing to stop emailing my patient information at any time, but if I do so, this will not affect emails that Mill Creek Dental already sent before receiving my written instructions to stop.

Patient name (please print): _____

Signature of patient (or parent): _____ Date: _____

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Cancellation/Missed Appointment Policy

We recognize there are times when an appointment is scheduled that you, the patient, has to cancel or postpone.

Our policy requires you to give a 48 business hour notice for any re-scheduled or cancelled appointments.

If less than a 48 business hour notice is given there will be a $50 late cancellation fee added to your account. Any appointments missed with no notice will have a $101 missed appointment fee added to your account.

We understand that occasionally a circumstance may arise which can cause missed appointments, but it does leave a void in our schedule that may have been used by another patient. We do not like to do this, however, in order to keep your patient fees lower we need to ensure all patients keep their scheduled appointments.

By signing below you have acknowledged and understand this policy.

Patient name (please print): _____

Signature of patient (or parent): _____ Date: _____

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Request for Release of Dental Records

(release is not required, but recent records are helpful for diagnosis)

Please release all x-rays less than five years old, a copy of all pertinent dental records (periodontal charting and treatment records) to:

Mill Creek Dental
Nikki H. Chin, D.D.S.
15808 Mill Creek Blvd. Ste. 130
Mill Creek, WA 98012

info@millcreekdentalwa.com

Patient Name(s):

_____

Name of Previous Dental Office:

_____

Phone Number of Previous Dental Office:

_____

Signature of Patient/Guardian:

_____