Karl Hoffman Dentistry PS

https://www.karlhoffmandentistry.com/ info@Karlhoffmandentistry.com
8685 Martin Way E | Suite 104 • Lacey, WA 98516 (360)456-7070

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 or update this form.

Whom may we thank for referring you to our practice? *

☐ Drove by Dental Office ☐ InternetSearch(name below) ☐ Insurance Co. Website ☐ Person (name below):

Name of person, office, or other source referring you to our practice:

PATIENT INFORMATION

Chart#: _____
FOR OFFICE USE ONLY

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **Prev. Visit:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ _____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

PRIMARY INSURANCE: (you don't need to fill out duplicate information)

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: _____ _____ ___ _____
Last First MI Preferred Name

Title: _____ **Gender:** ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date: _____ **SS#:** ___-__-____ **DL#:** _____

Email Address: _____ **Best time to call:** _____

Phone: _____ _____ _____ ____ _____ _____
Home Mobile Work Ext Fax Other

Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

PLEASE BRING IN YOUR INSURANCE CARD (You may scan and e-mail it)

SECONDARY INSURANCE:

Name of Insured: _____ _____ ___
Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

The following is for: ◯ the patient ◯ the person responsible for payment ◯ both ◯ not applicable

Employer Name: _____ **Phone:** _____

Employer Address: _____ _____
Address 1 Address 2

_____ ____ _____-____
City State Zip Code

Preferred appointment times:

☐ Mon ☐ Tue ☐ Wed ☐ Thur ☐ Fri ☐ Morning ☐ Afternoon ☐ Any time

AUTHORIZATION and RELEASE:

I authorize the dentist to release any informatin 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 payer's and/or other health care 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, regardless of insurance benefits.

Signature of patient, parent, or guardian (responsible party):

Signature _____ **Date** _____

Medical Health History

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] HIV
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Med for Osteoporosis
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Skin Rashes
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Thyroid
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Name and Phone Number of your Physician:

_____

_____

Please list all medications you are taking, including dosage and frequency:

_____

_____

_____

Do you drink alcohol, if so, how much?

_____

_____

Do you have any disease, condition, or problems that are not listed previously that we should know about ? If so please describe

_____

_____

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

- [ ] Local Anesthetics (Novocaine)
- [ ] Penicillin
- [ ] Any other antibiotics
- [ ] Sulfa drugs
- [ ] Barbiturates,Sedatives or sleeping pills
- [ ] Aspirin,Acetaminophen,Ibuprofen
- [ ] Codeine,Demerol,or other Narcotics.
- [ ] Reaction to metals
- [ ] Latex or Rubber dam
- [ ] Other

If you selected other please explain

_____

_____

During the past 12 months, have you taken any of the following?

- ◯ Antibiotics
- ◯ Anticoagulants (eg Coumadin)
- ◯ Aspirin
- ◯ Blood pressure Medicine
- ◯ Tranquilizers
- ◯ Insulin, Orinase or similar
- ◯ Digitalis or other heart med
- ◯ Nitroglycerin
- ◯ Cortisone (Steroids)
- ◯ Natural Remedies
- ◯ Nonprescription drug
- ◯ Supplements
- ◯ Other

List other:

Women:

☐ Contraceptives or other hormones ☐ Are you pregnant?

If so, Expected delivery date _____

Are you nursing? ◯ Yes ◯ No

Have you reached menopause? ◯ Yes ◯ No

If so, do you have any symptoms? ◯ Yes ◯ No

Dental Health History

Patient Name: _____ (Last) _____ (First) ____ (MI) _____ (Preferred Name)

Name and City of previous Dentist:

Date of last visit to Dentist _____

Why have you come to the Dentist today? Do you have concerns?

Do you require antibiotics before dental treatment? ◯ Yes ◯ No

Have you had problems with previous dental treatment? ◯ Yes ◯ No

Do you currently have any of the following?

☐ Currently in Pain? ☐ Sensitive Teeth? ☐ Slow healing sores in your mouth?

☐ Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)?

Do you like your smile? ◯ Yes ◯ No

Your dental health is?

☐ Good ☐ Fair ☐ Poor ☐ Idon't know

Do you prefer to save your teeth? ◯ Yes ◯ No

Would you like Whiter Teeth? ◯ Yes ◯ No

How many times per week do you floss? _____

How many times per week do you brush? _____

What kind or toothbrush do you use?

☐ Extra Soft ☐ Soft ☐ Medium ☐ Firm

Do you smoke or use other tobacco? if so , how much ?

BILLING and CANCELLATION POLICY/INFORMED CONSENT

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

OUR OFFICE POLICY

A BROKEN APPOINTMENT IS A LOSS TO EVERYONE. PLEASE INFORM US TWO DAYS IN ADVANCE IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT. A MINUMUM FEE OF $100 WILL BE CHARGED, UNLESS 48 HOURS NOTICE IS PROVIDED.

CONSENT:

a) The undersigned hereby, authorizes doctor to take x-rays, study models, photographs, and/or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. This office no longer treatment plans silver amalgam fillings. Insurance companies now pay on tooth-colored fillings, and, we can usually estimate accurately what portion of the procedure they will cover.
b) I also authorize doctor to perform all recommended treatment mutually agreed upon by me and and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
c) I understand that all responsibility for payment for dental services provided in this office for myself and/or dependents is mine, due and payable at the time services are rendered, unless other arrangements have been made. In the event that payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18%/year) may be added to my account.

☐ **By checking this box, I acknowledge that I have read the above statements and agree to the contents.**

BILLING POLICY:

Payment for services is expected at the time of treatment, unless financial arrangements are made prior to your appointment. For your convienience, we do accept American Express, Discovery, Master Card, Visa, personal checks, debit cards, and Care Credit.

INSURANCE:

a) Although this office files insurance claims as a service to the patient, the insurance contract is between you, the patient, and the insurance company. We have no control over the insurance company's method of payment, neither the amount nor timing; therefore, any agreement for payment of fees is between you the patient and this office, regardless of insurance
b) We will call your insurance company to determine an estimated percentage of the total fee to be paid. We ask you to pay the estimated amount not assured by your insurance company on the day of treatment.

☐ **By checking this box, I acknowledge that I have read the above statements and agree to the content.**

ACKNOWLEDGEMENT of PRIVACY PRACTICES:

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to;

a) Provide and coordinate my treatment among other health care providers who may be involved in that treatment directly and indirectly.
b) Obtain payment from third-party payers (insurance companies) for my health care services.
c) Conduct normal health care operations such as quality assessment and improvement activities.
I have been informed of my dental provider's "Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such "Notice of Privacy Practices." I understand that my dental provider has the right to change the "Notice of Privacy Practices" and that I may contact this office at the address above to obtain a current copy of the "Notice of Privacy Practices."
I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. This "Notice of Privacy Practices" is available on our website, or available in hard copy for viewing here in the office.

☐ **By checking this box, I understand and acknowledge the above statements about the privacy practices of this office,**

☐ Self ☐ Dependent family members also covered by this acknowledgement

PATIENT RECORDS REQUEST FORM

Patient Name: _____ _____ ____ _____
Last First MI Preferred Name

Karl Hoffman Dentistry ps
8685 Martin Way E Suite #104
Lacey, WA 98516
(360) 456-7070; (360) 456-2892 fax
E-mail: Info@KarlHoffmandentistry.com

Name of Patient(s) with date(s) of birth:

Address:

E-mail (most x-rays can be e-mailed):Please send x-rays to: info@karlhoffmandentistry.com

☐ * **Signature of patient (by checking box) I consent to transfer of the above records**

If not patient, name of authorized personal representative:

Relationship to patient:

Response Date: _____