Yelm Prairie Dental

Patient Name: _____ Preferred Name: _____

Date of Birth: _____ Male: _____ Female: _____ Married: _____ Single: _____ Child: _____

SSN: _____ Driver's License#: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

E-mail address: _____ Best way to reach you:_____

Employer: _____ Is it ok to contact you at work: Yes____ No____

Emergency Contact: _____Relationship:_____ Phone #:_____

How did you hear about us? _____

If referred by someone, whom may we thank for the referral? _____

Parent/Guardian Information (if patient is a minor):

Name: _____ Relationship to patient: _____

Date of Birth: _____ SS #: _____ Driver's license #: _____

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Dental Insurance Information (Primary):

Policyholder's Name: _____ Date of Birth: _____ SS #: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID #: _____

Patient Relationship to Policyholder: Self: _____ Spouse: _____ Child: _____ Other: _____

Dental Insurance Information (Secondary):

Policyholder's Name: _____ Date of Birth: _____ SS #: _____

Insurance Company: _____ Group #: _____

Employer: _____ Policyholder's ID #: _____

Patient Relationship to Policyholder: Self: _____ Spouse: _____ Child: _____ Other: _____

Medical History

Patient Name _____ **Date of Birth** _____

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(s) that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain:_____
_____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Have you ever taken Fosamax, Boniva, Actonel or any medications containing bisphosphonates*?* Yes No
Have you had any joint replacement? _____ **If yes, do you require pre-med?** Yes/No Dates? _____
Do you use tobacco? Yes No If yes, please explain: _____
Do you use controlled substances? Yes No If yes, please explain: _____
Are you taking medications, pills or drugs? Yes No If yes, please explain: _____
_____
_____
Women, are you: *Pregnant/trying to get* pregnant? Yes No *Taking oral contraceptives* Yes No *Nursing?* Yes No
Are you allergic to any of the following: (Please circle and that apply)
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other _____
What Pharmacy do you use:_____ (we cannot send to Madigan)
Do you have or have you had any of the following: (Please circle and that apply)

AIDS/HIV Positive	Excessive Bleeding	Mitral Valve Prolapse
Alzheimer's Disease	Fainting spells/Dizziness	Osteoporosis
Anaphylaxis: for?	Frequent Cough	Psychiatric Care
Anemia	Frequent Diarrhea	Radiation Treatments
Angina	Frequent Headaches	Recent Weight Loss
Arthritis/Gout (circle one)	Genital Herpes	Renal Dialysis
Artificial Heart Valve	Glaucoma	Rheumatic Fever
Artificial Joint	Heart Attack/Failure (circle one)	Rheumatism
Asthma	Heart Murmur	Scarlet Fever
Blood Disease	Heart Pacemaker	Shingles
High Blood Pressure	Heart Trouble/Disease	Sickle Cell Disease
Blood Transfusion	Hemophilia	Spina Bifida
Breathing Problem	Hepatitis A B or C (circle one)	Stomach/Intestinal Disease
Cancer	Herpes	Stroke
Chemotherapy	High Cholesterol	Swelling of Limbs
Cold Sores/Fever Blisters	Hives/Rash	Thyroid Disease
Congenital Heart Disorder	Hypoglycemia	Tonsillitis
Cortisone Medicine	Irregular Heartbeat	Tuberculosis
Diabetes	Kidney Problems	Tumors or Growths
Drug Addiction	Leukemia	Ulcers
Emphysema	Liver Disease	Venereal Disease
Epilepsy or Seizures	Lung Disease	Yellow Jaundice

Please list any illness not listed: _____
_____
_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's health. It is my responsibility to inform the dental office of any changes with my medical status. Signing is a release of records for us to check on medications through a pharmacy database before any procedure where the doctor requires it.

Date of Last Dental Visit: _____ Date of last x-rays: _____

In respect to any previous dental treatment, have you:

1. Ever fainted or had an allergic reaction? _____
2. Any other complications during dental treatment? If yes, describe _____
3. Used sedation during treatment: Nitrous Gas/Pills/IV Sedation _____
4. Had periodontal deep teeth cleanings? _____
5. Do your gums bleed on brushing or eating? _____
6. Have you noticed any gum swelling around your teeth? _____
7. Do you ever avoid any part of the mouth while brushing/chewing? _____
8. Are you dissatisfied with your teeth and their appearance? _____
9. Do you have an unpleasant taste or odor in your mouth? _____
10. Have you ever had any teeth removed? _____
    a. How long have these teeth been missing? _____
    b. Do you wear removable dental appliances? _____
11. Have your teeth shifted, are there spaces between your teeth now where there was none? _____
12. Are any of your teeth sensitive to heat, cold, pressure, or ache? _____
13. Do you grind your teeth or clench your jaw? _____
14. Do you have any pain or clicking in the jaw joint around your ear? _____
15. Have your jaw muscles ever been sore? If yes, describe: _____
16. Are there any sores or growths in your mouth? _____
17. Do you have any other dental concerns? _____
18. Why did you leave your last dentist? _____
19. What is your present dental problem? _____

Yelm Prairie Dental Financial, Missed Appt, Cancellation Policy

Thank you for choosing Yelm Prairie Dental, Dr. Matthew Lesh. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

*Cash, Check, Visa, MasterCard, Discover or American Express

*We offer a 5% courtesy discount to patients who pay for their treatment via cash/check who do not have insurance/membership.

*Convenient Monthly Payment Options from CareCredit or Cherry Financial

- Allow you to pay over time with 6- or 12-months interest-free
- No annual fees or pre-payment penalties

It is the policy of this dental practice to request payment at the time of service. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your treatment plan and any refund issued after insurance has paid in full.

For larger, more comprehensive treatment plans, a 50% deposit is required to secure your initial treatment appointment. Any special payment arrangements must be made prior to your appointment day. If you cancel your appointment due to financial issues on the same day, there will be a same day cancellation fee added.

We charge 24% interest annually on all accounts that are older than 30 days including a $10.00 billing fee. If you pay your estimated patient portion prior to treatment you will not be charged interest or a billing fee within the first 30 days on a remaining balance. Your insurance EOB is considered your first billing. A $10.00 late fee will apply to all accounts over 30 days.

For those using our text payment options: if payment is not received and requires a bill to be sent out; interest, late fee and billing fee will apply with first billing.

Confirmation of Appointments: If you do not confirm your appointment via text, email, phone call, or in person within 1 day of your appointment it will be cancelled. Confirmations are required for all appointments.

Memberships must be paid in full on the day of membership signup. They cannot be billed or backdated.

For patients with dental insurance, we are happy to work with your insurance company to maximize your benefits and directly bill them for reimbursement for your treatment. Your patient portion is due at the time of service, and it is your responsibility to ensure payment from your insurance carrier. We will attempt to answer any questions we can about your insurance and, when possible, we will assist in resolving complications with your insurance company. Please understand that we cannot speak on their behalf. Your insurance contract is an agreement between you, your employer, and/or your insurance carrier. If your insurance company has not paid (on your behalf) within 60 days, the full amount is due, unless we are working with you and the insurance company on an issue.

For those patients without insurance coverage, you will be responsible for payment on the day of treatment. If you are not able to pay in full, or if your treatment requires several visits, we have payment option for you. Please discuss payment arrangements with a member of our business office staff, payment arrangements must be set up before your appointment.

A fee is charged for patients who no-show or late cancel without 24 business hours' notice. We understand that things do happen and encourage you to call us. Keep in mind no shows and late cancellations are expensive for the dental practice – we reserved that appointment time for you and have all the staff here with the operatory ready. If you call ahead and reschedule that allows us to get another patient in who is waiting due to a full schedule.

First offence: $75 fee for every hour of your appointment that is late cancelled; $100 for every hour for a no show.

Second offence: $150 fee for every hour of your appointment that is late cancelled; $250 for every hour for a no show.

Third offence: You will be dismissed from the practice with cause.

The policy of Yelm Prairie Dental, Dr. Matthew Lesh is to charge $45 for returned checks.

If you have any questions, please do not hesitate to ask. We are here to help you get the dentistry you want and/or need.

Patient, Parent or Guardian Signature Date Patient Name (Please Print)

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You establish that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- ✓ Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- ✓ The practice reserves the right to change the privacy policy as allowed by law.
- ✓ The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
- ✓ The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- ✓ The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with members of your family? YES NO

If YES, please name the members approved: 1: _____

2: _____

This consent was signed by: _____ Relationship to Patient: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT: PLEASE LET US KNOW IF YOU WOULD LIKE ONE.

YELM PRAIRIE DENTAL
Matthew Lesh, D.M.D.
202 1st St S, Yelm, WA 98597
Phone (360)458-7645 Fax (360)458-2745

MEDICAL AND DENTAL RECORDS RELEASE

Please fill out the following information if you would like our assistance in obtaining any dental records and/or radiographs from another dental/medical provider.

I authorize to release my complete dental information from:

Doctor's Name/Office: _____

City & State of Doctors office: _____

Office Phone: _____

Office Email Address: _____

To:
Yelm Prairie Dental
202 1st St S. Yelm, WA 98597
Email: frontdesk@yelmprairiedental.com
Phone (360)458-7645

All Records needed:
- _x_ FMX/Pano
- _x_ BWX
- _x_ History of SRPs (if any) with dates UR/LR _____ UL/LL _____
- _x_ Perio Charting
- _x_ Implant information: tooth #s: _____
- _x_ Date of last hygiene visit: _____

Patient Full Name (Print): _____ Date of Birth: _____

Signature: _____ Date: _____
(Patient or Parent/Legal Guardian)

This is an electronic form that can only be filled out by the patient or Guardian of the patient.

Names of other family members on this release (full name and date of birth):

_____ _____

_____ _____