Yelm Prairie Dental

Patient Information:

Patient Name: _____ Preferred Name: _____

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

SSN: _____ Driver's License#: _____

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 #:_____

Other family members seen by us: _____

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
If yes, please explain: _____
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 _____

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	Frequent Cough	Psychiatric Care
Anemia	Frequent Diarrhea	Radiation Treatments
Angina	Frequent Headaches	Recent Weight Loss
Arthritis/Gout	Genital Herpes	Renal Dialysis
Artificial Heart Valve	Glaucoma	Rheumatic Fever
Artificial Joint	Heart Attack/Failure	Rheumatism
Asthma	Heart Murmur	Scarlet Fever
Blood Disease	Heart Pacemaker	Shingles
Blood Pressure Low or High	Heart Trouble/Disease	Sickle Cell Disease
Blood Transfusion	Hemophilia	Spina Bifida
Breathing Problem	Hepatitis A B or C	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

Have you ever had any serious 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.

Signature of patient_____

Relationship to patient _____ **Date**_____

Preferred Pharmacy: _____ Pharmacy Phone: _____

Pharmacy Address: _____

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, or American Express
*We offer a 5% courtesy discount to patients who pay for their treatment via cash/check on the day of treatment only.
*Convenient Monthly Payment Options from CareCredit Healthcare Credit Card

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

Please note:
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.

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.

We charge 24% interest annually on all accounts that are older than 30 days including a $5.00 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 $5.00 late fee will apply to all accounts over 30 days.

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

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 carrier to maximize your benefit 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 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, you will be given an estimate and will be able to discuss payment arrangements with a member of our business office staff.

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. If we can fill the appointment we do not charge for the late cancel.

First offence: $50 fee for every hour of your appointment
Second offence: $75 fee for every hour of your appointment
Third offence: $100 for every hour of your appointment, with full payment of rescheduled appointment due in advanced
The policy of Yelm Prairie Dental, Dr. Matthew Lesh is to charge $35 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 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 any member 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.

Patient Screening Form

Patient Name:

	PRE-APPOINTMENT	IN-OFFICE
	Date:	Date:
Do you/they have fever or have you/they felt hot or feverish recently (14-21 days)?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they having shortness of breath or other difficulties breathing?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have a cough?	☐ Yes ☐ No	☐ Yes ☐ No
Any other flu-like symptoms, such as gastrointestinal upset, headache or fatigue?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they experienced recent loss of taste or smell?	☐ Yes ☐ No	☐ Yes ☐ No
Are you/they in contact with any confirmed COVID-19 positive patients? *Patients who are well but who have a sick family member at home with COVID-19 should consider postponing elective treatment.*	☐ Yes ☐ No	☐ Yes ☐ No
Is your/their age over 60?	☐ Yes ☐ No	☐ Yes ☐ No
Do you/they have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?	☐ Yes ☐ No	☐ Yes ☐ No
Have you/they traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)	☐ Yes ☐ No	☐ Yes ☐ No

Positive responses to any of these would likely indicate a deeper discussion with the dentist before proceeding with elective dental treatment.

- For testing, see the list of State and Territorial Health Department Websites for your specific area's information.

Signature: _____ Date: _____