Swiftwater Dental

101 N. Harris Ave | PO BOX 580 • Cle Elum, WA 98922--0580 (509)674-5153

Welcome to our Practice

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

Spouse/Significant other/Parent Name

Whom may we thank for referring you to our practice?

In an emergency who should be notified? Please enter Name and Phone number below:

Primary Dental Insurance:

Name of Insured: _____ _____ ___
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Secondary Dental Insurance

Name of Insured: _____ _____ _____
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

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

Insurance Plan Name: _____

Insurance Address: _____ _____
Address 1 Address 2

_____ _____ _____-_____
City State Zip Code

☐ **By checking this box,**
I authorize my insurance to pay my benefits directly to the dentist for all services rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges, whether or not paid by insurance.

Medical History

Indicate which of the following you have had or have at present. By checking the box it will indicate a "Yes" response, leaving blank will indicate a "No" response.

- [ ] **Bisphosphonates**
- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] *Pre-Med-Anxiety
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Latex
- [ ] Allergy - Naproxen
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Allergy -Amoxicillin
- [ ] Artificial Joints
- [ ] Autoimmune Disease
- [ ] Blood Thinner
- [ ] Cancer
- [ ] Chemo/Radiation
- [ ] Diabetes Type 1
- [ ] Diabetes Type 2
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Pacemaker
- [ ] Respiratory Problems
- [ ] Sleep Apnea
- [ ] STD's
- [ ] Stroke
- [ ] Thyroid Disease
- [ ] Tuberculosis

- [ ] FEMALE: Pregnant
- [ ] FEMALE: Nursing
- [ ] FEMALE: Taking Birth Control

If any condition or alert selected above needs further clarification, please explain below:

Do you take antibiotic premedication for your dental visits? If yes, please explain.

Please list any medications you are currently taking, one medication per line:

Name of physician and their phone number, please include date of last physical exam:

Previous Dentist name and date of last visit:

Name of pharmacy and phone number:

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment:

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed unless other arrangements are made.

Patients with dental insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment, or within five (5) days of billing if credit is extended. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me to discuss this statement or my treatment.

Credit Card on File Billing Authorization Form

Swiftwater dental is offering a secure and convenient method of payment for services that your insurance doesn't cover, but for which you are liable. Your credit card information is kept confidential and secure. The card is only processed after a claim has been filed to and processed by your insurance carrier and the insurance portion of the claim has been posted to your account-or in the event that valid insurance information was not provided at the time of service.

I authorize Swiftwater Dental to capture my credit card information and securely store my credit card on file.

I agree Swiftwater Dental may charge my credit/debit card on file for the balance due when they receive a copy of the EOB. This authorization relates to balances not covered by my insurance company for services provided by Swiftwater Dental. This could be amounts resulting from balances related to co-payment, deductible, co-insurance, non-covered services, or denials for no coverage/eligibility but is not limited to these scenarios.

I understand this authorization is valid until I give a 30 day written notice to cancel the authorization to Swiftwater Dental. Written notice must be submitted to : Swiftwater Dental P O Box 580 Cle Elum, Wa. 98922. Account must be current at time of cancellation.

I certify that I am the authorized user of this credit card and I will not dispute the payment with my credit card company; so long as the transaction corresponds to the terms indicated in the form.

Cardholder name

_____

_____

Account Number/Expiration/Security Code

_____

_____

☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

If you choose to decline this authorization-we will allow one billing cycle after your dental procedures for you to pay in full. Failure to do so will result in you becoming a "pay as you go" patient regardless of your insurance.

******CANCELLATION POLICY******

We require a 48 hour notice (working days) for cancellations to avoid a charge.

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality,

I hereby authorize the following person(s) to have access to my personal information (HIPAA)

_____

_____

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the Financial Policy, Cancellation Policy and HIPAA Disclosure Form.**

Signature _____ **Date** _____

Response Date: _____