4TH & SENECA DENTAL

COMPLETION OF THIS FORM IN ITS ENTIRETY IS REQUIRED AT TIME OF VISIT/TREATMENT

Patient Information

Name: _____ Social Security # ____ - ____ - ____
LAST FIRST M.I.

Date of Birth: _____ Age: _____ Email Address: _____

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

Phone: (_____) _____ H: ☐ C: ☐ W: ☐

Employed by: _____ Occupation: _____

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

Spouse/Parent Name: _____ Social Security #: _____ - _____ - _____ DOB: _____

Employer: _____ Occupation: _____ Phone: (_____) _____

In Case of Emergency:

Contact Other than spouse/parent: _____ Phone: (_____) _____
Address: _____ City: _____ State: _____ Zip: _____

Who referred you to our practice? _____

Dental Insurance

Subscriber Name: _____ Social Security # _____ - _____ - _____

Insurance Co: _____ Insurance Phone: (_____) _____

Employer: _____

Secondary Insurance Information: ***If you have NO insurance, check here:*** ☐

Subscriber Name: _____ Social Security # _____ - _____ - _____
Insurance Co: _____ Insurance Phone: (____) _____
Employer: _____

If someone other than the patient is responsible for payment, complete the following:

Name: _____ Social Security #: ____ - ____ - ____ Phone: (____) _____
Relationship to Patient: _____
Address: _____ City: ____ State: ____ Zip: ____

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize that the doctor can use my records if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms policy.
I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of information by the doctor in scientific papers or demonstrations for educational purposes.
I certifiy that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: _____ **Date:** _____

4TH & SENECA
DENTAL

1119 4th Ave, Seattle, WA 98101
P: 206-623-4400 E: office@jaynedds.com

Missed Appointment Policy

Please note that our time is valuable and so is yours. We always strive to be on time for your reserved appointments. We require a minimum of **two office days notice** (Monday through Thursday 8:00 am- 5:00 pm) for any cancelled appointment, otherwise a missed appointment fee will be charged to your account. Our confirmation system is as follows:

- Email reminders are sent out one week prior to your scheduled appointment
- Courtesy phone calls are made 1-2 days prior to appointment
- Text message reminders are sent out the morning of your appointment.

Email Address for Confirmation: _____

Best Phone Number for Confirmation: _____

Type of Appointment	**Broken Appointment Fee**
• Hygiene Appointment	$50 per hour
• Doctor Appointment	$100 per hour
• Appointments requiring 3rd Party Services *72 hours notice of appointment change	$200 fee

I have read, understand and agree to comply with this Financial Policy.

Signature: _____ Date: _____

Patient Authorization to Use or Disclose Photography/Video

Please read and completed the entire form in order for Dr. Vo & Associates to process this request

I, _____authorize Dr. Vo and Associates to take and or reproduce photographs/video of my teeth or face for educational material, marketing material, and/or dental lectures and presentations.

Information to be used or disclosed: Photographs, video and/or electronic media.

Your privacy is important to us.

This authorization for release of records will **not** release the following specially protected information: Reproductive Care (applicable to minors only), Sexually transmitted diseases, mental health, drug and alcohol treatment and/or HIV/AIDS.

Expiration of Authorization:

This authorization expires when there is a written request from the patient to terminate this authorization.

By signing this page, I acknowledge that I have read and agreed to the terms of this agreement.

Signature (Patient or Person Authorized to Give Authorization):

_____ Date: _____

If signed by person other than patient, print name, provide reason, relationship to patient, and description of their authority.

_____

Potential for Re-disclosure: Once disclosed, the law does not always require the recipient of your information to keep it confidential.

Revocation: This authorization may be revoked by submitting a request in writing to:

Dr. Vo & Associates
1119 4th Ave
Seattle, WA 98101

Note: A request to revoke this authorization will not affect any actions already taken based on the original authorization, or prevent Dr. Vo from requiring the information in order to be paid for treatment that you receive.

I understand I have the right to:

- Inspect or to receive a copy of my protected health information
- Receive a copy of this signed form
- Refuse to sign this form for authorization to disclose or release my protected health information.

I also understand Dr. Vo will not base treatment or payment decisions on receipt of this signed authorization.

Patient Name: _____ DOB: _____

4TH & SENECA
DENTAL

Dr. Jonathan Vo & Dr. Don Jayne
1119 - 4th Ave
Seattle, Washington 98101

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

- **Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly**
- **Obtain payment from third-party payers for my health care services**
- **Conduct normal health care operations such as quality assessment and improvement activities**

I have been informed of my health care 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;* importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

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.

Patient Name: _____ **Date**: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)

Other-Specify	**Names**	**Signatures**	**ID**

- - - - - - - - - - - For Office Use Only - - - - - - - - - - - - -

We were unable to obtain the patient's written acknowledgement of our *Notice of Privacy Practices* due to the following reason: The patient refused to sign:_____ Communication Barriers: _____ Emergency Situation: _____ Other: _____

DENTAL HISTORY

Patient Name _____ Nickname _____ Age _____

Referred by _____ How would you rate the condition of your mouth? ☐Excellent ☐Good ☐Fair ☐Poor

Previous Dentist _____ How long have you been a patient? _____ Months/Years

Date of most recent dental exam ____ /____ /____ Date of most recent x-rays ___ /____ /____

Date of most recent treatment (other than a cleaning) ____ /____ /____

I routinely see my dentist every ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

		YES	NO
PERSONAL HISTORY			
1.	Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____]	☐	☐
2.	Have you had an unfavorable dental experience?	☐	☐
3.	Have you ever had complications from past dental treatment?	☐	☐
4.	Have you ever had trouble getting numb or had any reactions to local anesthetic?	☐	☐
5.	Did you ever have braces, orthodontic treatment or had your bite adjusted, and at what age?	☐	☐
6.	Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	☐	☐
GUM AND BONE			
7.	Do your gums bleed sometimes or are they ever painful when brushing or flossing?	☐	☐
8.	Have you ever been treated for gum disease, had scaling and root planing, or been told you have lost bone around your teeth?	☐	☐
9.	Have you ever noticed an unpleasant taste or odor in your mouth?	☐	☐
10.	Is there anyone with a history of periodontal disease in your family?	☐	☐
11.	Have you ever experienced gum recession, or can you see more of the roots of your teeth?	☐	☐
12.	Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	☐	☐
13.	Have you experienced a burning or painful sensation in your mouth not related to your teeth?	☐	☐
TOOTH STRUCTURE			
14.	Have you had any cavities within the past 3 years?	☐	☐
15.	Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	☐	☐
16.	Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	☐	☐
17.	Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	☐	☐
18.	Do you have grooves or notches on your teeth near the gum line?	☐	☐
19.	Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	☐	☐
20.	Do you frequently get food caught between any teeth?	☐	☐
BITE AND JAW JOINT			
21.	Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	☐	☐
22.	Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	☐	☐
23.	Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	☐	☐
24.	In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	☐	☐
25.	Are your teeth becoming more crooked, crowded, or overlapped?	☐	☐
26.	Are your teeth developing spaces or becoming more loose?	☐	☐
27.	Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	☐	☐
28.	Do you place your tongue between your teeth or close your teeth against your tongue?	☐	☐
29.	Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	☐	☐
30.	Do you clench or grind your teeth together in the daytime or make them sore?	☐	☐
31.	Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	☐	☐
32.	Do you wear or have you ever worn a bite appliance?	☐	☐
SMILE CHARACTERISTICS			
33.	Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	☐	☐
34.	Have you ever bleached (whitened) your teeth?	☐	☐
35.	Have you felt uncomfortable or self conscious about the appearance of your teeth?	☐	☐
36.	Have you been disappointed with the appearance of previous dental work?	☐	☐

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic or bad reaction to any of the following:	☐	☐
○ aspirin, ibuprofen, acetaminophen, codeine _____		
○ penicillin _____		
○ erythromycin _____		
○ tetracycline _____		
○ sulfa _____		
○ local anesthetic _____		
○ fluoride _____		
○ chlorhexidine (CHX) _____		
○ Iodine _____		
○ metals (nickel, gold, silver, _____)		
○ latex _____		
○ nuts _____		
○ fruit _____		
○ milk _____		
○ red dye _____		
○ other _____		
3. heart problems, or cardiac stent within the last six months _____	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. orthopedic or soft tissue implant (e.g joint replacement, breast implant) ___	☐	☐
8. heart murmur, rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (or INR > 3.5) _____	☐	☐
13. pneumonia, emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. chronic ear infections, tuberculosis, measles, chicken pox _____	☐	☐
15. breathing problems (e.g. asthma, stuffy nose, sinus congestion) _____	☐	☐
16. sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting) __	☐	☐
17. kidney disease _____	☐	☐
18. liver disease or jaundice _____	☐	☐
19. vertigo (e.g. "the room is spinning") _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome) ____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates) _____	☐	☐
27. arthritis or gout _____	☐	☐
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma) _____	☐	☐
29. glaucoma _____	☐	☐
30. contact lenses _____	☐	☐
31. head or neck injuries _____	☐	☐
32. epilepsy, convulsions (seizures) _____	☐	☐
33. neurologic disorders (e.g. Alzheimer's disease, dementia, prion disease) _	☐	☐
34. viral infections and cold sores _____	☐	☐
35. any lumps or swelling in the mouth _____	☐	☐
36. hives, skin rash, hay fever _____	☐	☐
37. STI/STD/HPV _____	☐	☐
38. hepatitis (type ____) _____	☐	☐
39. HIV/AIDS _____	☐	☐
40. tumor, abnormal growth _____	☐	☐
41. radiation therapy _____	☐	☐
42. chemotherapy, immunosuppressive medication _____	☐	☐
43. emotional difficulties _____	☐	☐
44. psychiatric treatment or antidepressant medication _____	☐	☐
45. concentration problems or ADD/ADHD _____	☐	☐
46. alcohol/recreational drug use _____	☐	☐
ARE YOU:		
47. presently being treated for any other illness _____	☐	☐
48. aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea) _____	☐	☐
49. taking medication for weight management _____	☐	☐
50. taking dietary supplements, vitamins, and/or probiotics _____	☐	☐
51. often exhausted or fatigued _____	☐	☐
52. experiencing frequent headaches or chronic pain _____	☐	☐
53. a smoker, smoked previously or other (e.g. smokeless tobacco, vaping, e-cigarettes, and cannabis) _____	☐	☐
54. considered a touchy/sensitive person _____	☐	☐
55. often unhappy or depressed _____	☐	☐
56. taking birth control pills _____	☐	☐
57. currently pregnant _____	☐	☐
58. diagnosed with a prostate disorder _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections) _____

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.

Drug	Purpose	Drug	Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

ASA _____ **(1-6)**