MOUNTAIN VIEW
DENTAL CENTER

Welcome

708 E. Mountain View Ave Ellensburg, WA 98926
(509) 962-2755 ◆ ellensburgdentist.com

Date: _____

Patient Information

Full Name: _____ Middle Initial: _____

Parent or Guardian Name (if patient is minor): _____

Nickname: _____ Driver's License No.:_____

Date of Birth: _____ Gender: _____ SSN: _____

Address: _____ City/State: _____ Zip: _____

Cell Phone: (_____)_____ Home Phone: (_____)_____

Email: _____ Marital Status: _____

Employer/Occupation: _____

How did you hear about out office (Name of referral)?: _____

Bonus Question: What is one fun fact about you? _____

Emergency Contact Name: _____ Phone: _____

Primary Care Physician: _____ Pharmacy: _____

Insurance Information

Primary Dental Insurance: _____ Group No.: _____

Subscriber's Name: _____ Date of Birth: _____

Employer: _____

Secondary Dental Insurance: _____ Group No.: _____

Subscriber's Name: _____ Date of Birth: _____

Employer: _____

Authorization and Release

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care for myself or my child.
I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for dental insurance benefits.
I authorize the release of information concerning my (or my child's) health care to another health care practitioner, if needed, for the purpose of coordinating and administering treatment.

_____

Signature of patient or parent/guardian of minor Date

Thank you for filling out this form completely. Please let us know if you have any questions.

M V C D

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HEALTH QUESTIONNAIRE

Name:_____ **Sex:**_____ **Date of Birth:**_____ **Age:**_____

PLEASE √
YES / NO

☐ ☐ Is there any condition in your mouth, head, or neck causing you discomfort or swelling?

☐ ☐ Are you under a Doctor's care now? Doctor: _____ Reason: _____

☐ ☐ Are you taking any pills or medicines at this time, including birth control pills? Please List: _____

_____

☐ ☐ Are you taking any Bisphosphonates by mouth or IV, specifically: Evista, Miacalcin, Fosamax, Premarin, Boniva, Actonel or Zometa? List: _____

☐ ☐ Have you ever had a bleeding problem that needed medical treatment?

☐ ☐ Have you ever been diagnosed with a heart murmur, heart defect, heart attack or heart disease?

☐ ☐ Have you ever had surgery, x-ray treatment, cancer or been hospitalized for any major illness or injury? List:

☐ ☐ Do you use tobacco, chew or marijuana? If yes, how much? _____

☐ ☐ Are you pregnant? If yes, number of months? _____

☐ ☐ Do you have artificial joints (hip, knee, elbow) or artificial heart valves?

☐ ☐ Do you have a heart pacemaker?

☐ ☐ Are you allergic to or made sick by medicine such as aspirin, penicillin, or codeine?

☐ ☐ Do you have reason to believe you have been exposed to AIDS or HIV?

☐ ☐ Do you have sores in your mouth that do not heal?

☐ ☐ Do you have night sweats accompanied by weight loss or cough?

☐ ☐ Is there any other information about your health that I should know prior to treatment?

☐ ☐ Have you had problems with prior dental treatment? If yes, explain: _____

_____

Have you ever had any of the following health issues (check all that apply)?

- ☐ **Rheumatic Fever**
- ☐ **Diabetes**
- ☐ **Arthritis/Rheumatism**
- ☐ **Hepatitis/ Liver problems**
- ☐ **Stomach Ulcers**
- ☐ **Chest Pain/Stroke**
- ☐ **High/Low Blood Pressure**
- ☐ **Sinus Trouble**
- ☐ **Tuberculosis (TB)**
- ☐ **Seizures/Fainting/Epilepsy**
- ☐ **Asthma/Hay Fever**
- ☐ **Cancer/Chemotherapy/Radiation Treatment**
- ☐ **Kidney Problems**
- ☐ **Sexually Transmitted Disease**
- ☐ **Latex Allergy**

Have ever noticed yourself: ☐ **Snore** ☐ **Clench** ☐ **Grind**

These answers I have given are true to the best of my knowledge. I am indicating my consent for the routine dental procedures such as x-rays, cleaning, fillings, crowns, and local anesthesia by signing below. I will inform Mountain View Dental of any changes that may occur.

Patient or Parental Consent_____ **Date**_____
Reviewed By:_____ **Date**_____
2nd Review (Initials/Date) _____ **3rd Review (Initials/Date)** _____

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Payment Policy

Thank you for entrusting our dental office with your dental care.
Please contact our office if you have any questions about your financial options.

Patient portion is DUE AT THE TIME OF SERVICE. We will estimate your copayments and insurance benefits before beginning any dental treatment. These estimated copays and deductibles are due at the time of service and insurance will be filed as a courtesy to you.

However, if after **90 days** your insurance company has not paid all remaining charges, you will become responsible for the account balance. Insurance follow up and reimbursement attempts also become your responsibility.

Methods of Payment

Cash or Check, Credit Card, HSA Card, Care Credit

Estimate Only

Please be advised that our office is limited to information we can receive from your insurance company. Treatment plans are ESTIMATES ONLY. Copays and deductibles are based upon these estimates. Our office will inform you of any changes with your treatment plan as they occur. However, it is the patient's responsibility to know their insurance exclusions, limitations and their usual and customary fee schedules as these items are rarely provided to our office.

Reservation & Cancellation

_____
initial

When you book your appointment for treatment, time is reserved specifically for you and your procedure. Patients who do not give **48 hours notice** to reschedule or "no show" to the appointment will be assessed a **$50** missed appointment fee. If appointments are failed regularly, patients may be asked to pay in part or full for the treatment at the time of scheduling.

Finance Charges

Patient estimated fees are due at the time of service. If I do not pay the entire balance on my accounting within 90 days of the date of service, a finance charge of 1.5% on the balance then unpaid and owed will be assessed each month thereafter. I realize that failure to keep my account current may result in Dr. Joshua Kirk being unable to provide additional dental services except for dental emergencies or where there is prepayment for additional service. In the case of default on payment of my account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount or any future outstanding balances.

Authorization and Release

I authorize the dentist to release any information 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 payers and/or other health care practitioners.
I authorize and request my insurance company to pay directly to the dentist or dental office the 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.
I further understand that if collection action is taken on my account and court action is necessary, the venue will be in Kittitas County.

By my signature below, I acknowledge receipt of this payment policy, authorization and release.

_____	_____	_____
Patient Signature	PRINT Name	Date

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Credit Card Authorization Form

The listed credit card may be used for estimated patient portion, no-show fee(s) or to remit the entire balance of the account if dental insurance does not pay within 90 days of treatment.

CARDHOLDER INFORMATION

Name: _____

Billing Street Address: _____

City: _____State: _____ Postal Code: _____

Email: _____

Phone: (_____) _____-_____

I authorize the office of Mountain View Dental Center to use the payment method listed below for the estimated patient portion above what my dental insurance benefits cover. I also acknowledge that if my insurance benefits are not paid in full after 90 days, my account balance is due in full and is authorized using the payment method below.

CREDIT CARD INFORMATION

Credit Card Type: □ MasterCard □ Visa □ American Express □ Discover Card

Number: _____

Expiration Month/Year: _____/_____ Security Code: _____

Cardholder Signature: _____ Date: _____

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Acknowledgment of Privacy Practices

Mountain View Dental Center keeps a record of the health care services provided to you pursuant to the Health Insurance Portability and Accountability Act of 1996, as amended by Federal law (HIPAA) and RCW 70.02.120. My signature below confirms that 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 my protected health 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 and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

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. 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. Written requests should be sent to the address above.

OPTIONAL: I give Mountain View Dental Center permission to share my health information and have discussions with:

_____ _____
Person Relationship

☐ **I was offered and I declined a copy of Mountain View Dental Center's Notice of Privacy Practices.**

_____ _____
Patient or Authorized Individual Signature Date

_____ _____
Print Name (if signed on behalf of patient) Relationship to Patient

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frontdesk@ellensburgdentist.com

Authorization to Release Information

Date: _____

I authorize: _____

_____

_____

to release dental records, x-ray(s) and treatment needs for the purpose of further dental treatment to:

Mountain View Dental Center
708 E. Mountain View Dental Center
Ellensburg, WA 98926

_____	_____	_____
Print Name	Date of Birth	Patient Signature