NORTH SEATTLE DENTAL
Patient Information

Date _____

Patient Name _____
Last First MI Preferred

Address _____
Street Apt # City State Zip code

Birth Date_____ Gender ☐ Male ☐ Female Family Status ☐ Married ☐ Single ☐ Child ☐ Other

Social Security # _____ Driver's License #_____

Home Phone # _____ Work #_____ext_____ Cell #_____

Email Address _____ Preferred Contact (Choose 1): ☐ Home ☐ Work ☐ Cell ☐ Email

Employer Name _____ How long? _____ Occupation _____

Whom May We Thank for Referring you? _____

Spouse or Responsible Party Information

Name _____ ☐ the patient's spouse ☐ person responsible for payment if other than patient

Address _____
Street Apt # City State Zip code

Home Phone # _____ Work #_____ext_____ Cell #_____

Emergency Contact
Neighbor or Relative not living with you

Name _____ Relationship _____

Address _____
Street Apt # City State Zip code

Home Phone # _____ Work #_____ext_____ Cell #_____

Dental Insurance Information

Primary

Name of Employee _____ ☐ Self ☐ Spouse ☐ Other
Last First MI

Employee's Birth Date: _____ ID #: _____ Group # (Plan, Local or Policy):_____

Insured's Address: _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____

Secondary

Name of Employee _____ ☐ Self ☐ Spouse ☐ Other
Last First MI

Employee's Birth Date: _____ ID #: _____ Group # (Plan, Local or Policy):_____

Insured's Address: _____

Insurance Company Name _____ Phone # _____

Insurance Company Address _____

Do You Have a flex spending account?_____If yes, do you need help coordinating?_____

Consent for Services

I certify that I am covered by the above stated insurance co. and I assign directly to Dr. _____ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any portion that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ Date: _____ Relationship to Patient: _____
Signature of patient, parent or guardian

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

HAVE YOU EVER HAD THE FOLLOWING:	YES	NO
1. hospitalization for illness or injury.....	☐	☐
If Yes, why? _____		
2. allergic reaction to:		
☐ aspirin, ibuprofen, acetaminophen		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ codeine		
☐ local anesthetic		
☐ fluoride		
☐ metals (gold, stainless steel)		
☐ latex		
☐ glutens		
☐ any other medications_____		
3. heart problems.....	☐	☐
4. heart murmur.....	☐	☐
5. rheumatic fever.....	☐	☐
6. scarlet fever.....	☐	☐
7. high blood pressure.....	☐	☐
8. low blood pressure.....	☐	☐
9. stroke.....	☐	☐
10. artificial prosthesis (i.e. heart valve or joint)...	☐	☐
11. anemia or other blood disorders.....	☐	☐
12. prolonged bleeding due to a slight cut.....	☐	☐
13. emphysema.....	☐	☐
14. tuberculosis.....	☐	☐
15. asthma.....	☐	☐
16. sinus problems.....	☐	☐
17. kidney disease.....	☐	☐
18. liver disease.....	☐	☐
19. jaundice.....	☐	☐
20. thyroid or parathyroid disease.....	☐	☐
21. hormone deficiency.....	☐	☐
22. high cholesterol.....	☐	☐
23. diabetes.....	☐	☐
24. stomach or duodenal ulcer.....	☐	☐

	YES	NO
25. digestive disorders.....	☐	☐
26. arthritis.....	☐	☐
27. glaucoma.....	☐	☐
28. contact lenses.....	☐	☐
29. head or neck injuries.....	☐	☐
30. epilepsy, convulsions (seizures).....	☐	☐
31. viral infections and cold sores.....	☐	☐
32. any lumps or swelling in the mouth.....	☐	☐
33. hives, skin rash, hay fever.....	☐	☐
34. venereal disease.....	☐	☐
35. hepatitis (type___).....	☐	☐
36. HIV/ AIDS.....	☐	☐
37. tumor, abnormal growth.....	☐	☐
38. radiation therapy.....	☐	☐
39. chemotherapy.....	☐	☐
40. psychiatric treatment.....	☐	☐
41. antidepressant medication.....	☐	☐
42. alcohol/drug dependency.....	☐	☐
42a. do you wish to avoid prescription pain medications due to past history?.....	☐	☐
43. human papilloma virus (HPV).....	☐	☐
44. oral cancer.....	☐	☐
45. family history of periodontal disease.....	☐	☐
ARE YOU:		
46. presently being treated for any other illness...	☐	☐
47. aware of a change in your general health.....	☐	☐
48. taking medication for osteoporosis/osteopenia	☐	☐
49. taking bisphosphonates (i.e. Fosamax).....	☐	☐
50. often exhausted or fatigued.....	☐	☐
51. subject to frequent headaches.....	☐	☐
52. a heavy smoker (1 pack or more a day).....	☐	☐
53. using any other type of tobacco product.....	☐	☐
54. FEMALE- taking birth control.....	☐	☐
55. FEMALE- pregnant.....	☐	☐
56. MALE- prostate disorders.....	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment_____

List any medications, supplements, and/or vitamins you are currently taking.

DRUG	PURPOSE	DRUG	PURPOSE
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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

Patient's Signature_____ Date_____

Christopher Pickel, DDS, PS and Leah L. Worstman, DDS, PLLC North Seattle Dental 11011 Meridian Ave N. Suite #301
Seattle, WA 98133

DENTAL HISTORY

My previous dentist was _____ whom I had been a patient for_____ months/years.
Are you satisfied with your past dentistry? ☐Yes ☐No.
What condition is your mouth in?
☐Excellent ☐Good ☐Fair ☐Poor.
I (☐don't) go routinely every_____months/years.
The interval was selected by
☐Me or ☐My dentist/hygienist.

Date of most recent dental exam/cleaning___/___/___.
Most recent x-rays ____/____/____
☐4BW ☐18FMX or ☐Pano.
Date of most recent dental treatment (besides a cleaning)
____/____/____.
Treatment performed_____.

Purpose for Today's visit? _____

YES	NO	
☐	☐	Are you dental phobic?
☐	☐	Have you had an unfavorable dental experience?
☐	☐	Have you ever had complications from past dental treatments?
☐	☐	Have you ever had trouble getting numb or reactions to local anesthetic?
☐	☐	Have you ever had teeth extracted?
☐	☐	Did you ever have braces or orthodontic treatment?
☐	☐	Are you unhappy with the appearance of your teeth?
☐	☐	Have you ever bleached your teeth and or would like a whiter smile?
☐	☐	Do you have existing crowns or dental work, which you consider "ugly"?
☐	☐	Do you have crowded or crooked teeth that bother you?
☐	☐	Are you self-conscious of your teeth or smile of has anyone suggested you change your smile?
☐	☐	Have you noticed any spots or stains on your teeth?
☐	☐	Have you had any cavities within the past 3 years?
☐	☐	Do you have any root canals, crowns, bridges or dental implants?
☐	☐	Do you have dry mouth?
☐	☐	Are any teeth sensitive to hot, cold, biting, or sweets?
☐	☐	Have you ever had a toothache, cracked filling, broken, chipped or cracked tooth?
☐	☐	Do you have difficulty opening, closing, or chewing certain types of foods, i.e. gum or bagels?
☐	☐	Do you have more than one bite or do you feel like you can't find "home"?
☐	☐	Have you noticed that your teeth have become ☐**shorter** or ☐ **worn down**?
☐	☐	Are you a restless sleeper? (Difficulty sleeping or covers disheveled upon waking?)
☐	☐	Jaw problems (Pain in or around your jaw joint, jaw joint sounds, or limited ability to open)?
☐	☐	Do you have tension headaches or stiff neck muscles?
☐	☐	Are you aware of, or has someone told you that you grind or clench your teeth?
☐	☐	Do you wear a splint, night guard, or have had an injury to the head/neck due to an auto accident?
☐	☐	Have you ever been diagnosed or treated for periodontal disease (pyorrhea)?
☐	☐	Have you experienced gum recession or loose teeth, or teeth movement or shifting within the past two years?
☐	☐	Do you or have you ever used tobacco? (Packs/day_____) When did you quit? _____.
☐	☐	Is there anyone with a history of periodontal disease in your family?
☐	☐	Do your gums bleed when brushing, flossing or eating?
☐	☐	Do you brush less than twice a day? I floss once per ☐Day ☐Week ☐Month ☐Year ☐Never

Patient's Signature_____ Date_____

Christopher Pickel, DDS, PS and Leah L. Worstman, DDS, PLLC North Seattle Dental 11011 Meridian Ave N. Suite #301
Seattle, WA 98133

NORTH SEATTLE DENTAL

Christopher Pickel, DDS, PS
Leah D. Worstman, DDS, PLLC

PATIENT: _____

Dental Insurance:
As a courtesy service, our practice accepts most dental insurance plans including indemnity (traditional) and PPO "out-of-network". We are not part of any managed-care or PPO network. The fees charged for services rendered to those who are insured are the usual and customary fees charged to all patients for similar services. Your policy may base allowances on a fixed fee schedule, which may or may not coincide with our fees. We will provide you with an estimate based on our examination and any additional requests you have. The insurance estimate is provided as a courtesy based on the limited information we have about your insurance. If additional unforeseen treatment is required as treatment progresses, you will be consulted before it is completed. You may ask for a revised estimate at that time. **Your estimated patient portion is due in full at the time of service.** Please keep in mind that if your insurance carrier pays less than the estimated amount, you are responsible for the unpaid balance.

Non-insured patients:
We will provide you with an estimate based on our examination and any additional requests you have. **Payment is due in full the day of service** unless other arrangements have been made prior to the treatment date.

Payment:
For your convenience, we accept cash, check, Visa and Mastercard. We also extend a 7% senior discount for our 65+ patients when payment in full is made the time of service.

Additional Products:
Additional products may be recommended as part of your treatment and can be purchased from our office. These items must be paid for at the time of dispensing. Products may include: Clinpro 5000 Toothpaste, Prevident, Periomed, Peridex, CariFree and bleaching gel. Nitrous oxide is available at $40 per hour.

Missed and cancelled appointments:
Your appointment is a time specifically reserved for you. We offer flexible hours and strive to accommodate your schedule so you can receive treatment as conveniently as possible. If you foresee a conflict, we require 48 hours notice to reschedule your appointment. This is necessary so that we may see other patients that require emergency treatment or urgent care. **A fee of $75 per hour will be charged for a broken appointment without 48 hours notice.** It is your responsibility to keep your appointments and we will assist you in any way we can to help you receive the highest standard of dental care.

Patient Signature _____ Date _____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

North Seattle Dental
11011 Meridian Ave N, Suite 301
Seattle, WA 98133
(206) 524-1000

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act 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 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 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 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:

____

May we discuss treatment with:

☐ All family members ☐ Spouse only ☐ Other:____________________________

- -

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

NORTH SEATTLE DENTAL

Consent for
VELscope Oral Cancer
Examination

Patient Name: _____

1. The purpose of this screening examination for oral cancer with the Visually Enhanced Lesion Scope (VELscope) has been explained to me. This is in addition to the current visual oral exam.
2. I understand that this is an elective procedure and that this test is only a screening test. I understand that a perfect result is not guaranteed or warranted, and that if needed, follow up treatment by another specialist may be required.
3. I authorize Christopher Pickel, D.D.S., Leah Worstman, D.D.S. and any associates to perform the Visually Enhanced Lesion Scope (VELscope) oral cancer examination.
4. At the present time, the VELscope exam is not a covered benefit by insurance companies. The fee is $35.

Please circle to either accept or decline this service at today's visit.

ACCEPT DECLINE

Patient Signature:_____Date:_____