Welcome to
our family.

Jeffrey A Stewart D.D.S.
FAMILY DENTISTRY • IV SEDATION
IMPLANTS • COSMETIC DENTISTRY

253.756.8644
1919 North Pearl Street, Suite B-4
Tacoma, WA 98406
www.besttacomadentist.com

NEW PATIENT INFORMATION PACKET

Welcome to our office! We appreciate the confidence you place with us to provide you and your family dental services. To assist us in serving you, please complete the following form. The information you provide is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient Name: _____ Date of Birth: _____ Sex: _____ Age: _____
Home Address: _____ City: _____ State: _____ Zip: _____
Billing Address (if different): _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____ E-mail: _____
Driver's License #: _____ State: _____ Social Security #: _____-_____-_____
Employer: _____ Occupation: _____ Business Phone: _____
Spouse's Name: _____ Spouse's Phone #: _____ Emergency Phone #: _____
Primary Dental Insurance: _____ Group #: _____
Secondary Dental Insurance: _____ Group #: _____
Subscriber's Name: _____ Date of Birth: _____ Social Security #: _____-_____-_____
Name of your Medical Doctor: _____ Date of last visit to your Medical Doctor: _____
Name of your Previous Dentist: _____ Date of last visit to your Previous Dentist: _____
Referred to us by: _____

Dental Health History

	YES	NO
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch betwen your teeth?	☐	☐
Do you have difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take flouride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐

	YES	NO
Do you want complete dental care?	☐	☐
How often do you brush your teeth?	☐	☐
How often do you floss your teeth?	☐	☐
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open it freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches after waking up?	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort? (pain relievers, muscle relaxants, antidepressants?)	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

Jeffrey A Stewart D.D.S.
FAMILY DENTISTRY • IV SEDATION
IMPLANTS • COSMETIC DENTISTRY

	YES	NO
Health Problems?	☐	☐
Chest Pain?	☐	☐
Shortness of Breath?	☐	☐
Blood Pressure Problem?	☐	☐
Heart Murmer?	☐	☐
Heart Valve Problem?	☐	☐
Taking Heart Medication?	☐	☐
Rheumatic Fever?	☐	☐
Pacemaker?	☐	☐
Artificial Heart Valve?	☐	☐
Blood Problems?	☐	☐
Easy Bruising?	☐	☐
Frequent Nosebleeds?	☐	☐
Abnormal Bleeding?	☐	☐
Blood Disease (anemenia)?	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems?	☐	☐
Hay Fever?	☐	☐
Sinus Problems?	☐	☐
Skin Rashes?	☐	☐
Taking Allergy Medication?	☐	☐
Asthma?	☐	☐
Intestinal Problems?	☐	☐
Ulcers?	☐	☐
Weight Gain or Loss?	☐	☐
Special Diet?	☐	☐
Constipation or Diarrhea?	☐	☐
Kidney or Bladder Problems?	☐	☐
Bone or Joint Problems?	☐	☐
Arthritis?	☐	☐
Back or Neck Pain?	☐	☐
Joint Replacement (total hip, pins or implants)?	☐	☐
Fainting Spells, Seizures or Epilepsy?	☐	☐
Stroke(s)?	☐	☐
Frequent or Severe Headaches?	☐	☐
Thryoid Problems?	☐	☐
Persistent Cough or Swollen Glands	☐	☐
Premedications required by your Physician	☐	☐
Cancer or Tumor?	☐	☐

Are you allergic, or have you reaced adversely, to any of the following:

Local Anesthetics ("Novocaine")?	☐	☐
Penicillin or other Antibiotics?	☐	☐
Sulfa Drugs?	☐	☐
Barbituates, Sedatives, or Sleeping Pills?	☐	☐
Aspirin, Acetaminophen, or Ibuprofen?	☐	☐
Codeine, Demerol, or Other Narcotics	☐	☐
Reaction to Metals?	☐	☐
Latex or Rubber Dam?	☐	☐

Other: _____

	YES	NO
Diabetes?	☐	☐
Urinate more than 6 times a day?	☐	☐
Thirsty or mouth is dry much of the time?	☐	☐
Family history of diabetes?	☐	☐
Tuberculosis or other respiratory disease?	☐	☐
Do you drink alcohol?	☐	☐
If so, how much?		
Do you smoke?	☐	☐
If so, how much?		
Hepatitis jaundice or liver trouble?	☐	☐
Herpes or other STD?	☐	☐
HIV-positive or AIDS?	☐	☐
Glaucoma?	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or problem not listed previously which you feel we should know about? If so, please describe:	☐	☐

During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs?	☐	☐
Anticoagulants (e.g. Coumadin)?	☐	☐
High blood pressure medecine ?	☐	☐
Tranquilizers?	☐	☐
Insulin, Orinase, or similar drug?	☐	☐
Aspirin?	☐	☐
Digitalis or drugs for heart trouble?	☐	☐
Nitroglycerin?	☐	☐
Cortisone (steroids)?	☐	☐
Natural remedies?	☐	☐
Non-prescription drug/suppliments?	☐	☐

Other: _____

Women

Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have symptoms?		

Notes: _____

Patient / Parent Signature: _____ Doctor Signature: _____

Date: _____ Date: _____

Jeffrey A Stewart D.D.S.
FAMILY DENTISTRY • IV SEDATION
IMPLANTS • COSMETIC DENTISTRY

253.756.8644
1919 North Pearl Street, Suite B-4
Tacoma, WA 98406
www.besttacomadentist.com

Acknowledgement Of Privacy Practices

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 cares services.
- Conduct normal health cares 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 discolsures 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. I also understand that you are not required to agree to my request 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 by this acknowledgement:_____

_____

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(s):

☐ Patient refused to sign ☐ Emergency Situation ☐ Communication Barriers ☐ Other

Jeffrey A Stewart D.D.S.
FAMILY DENTISTRY • IV SEDATION
IMPLANTS • COSMETIC DENTISTRY

253.756.8644
1919 North Pearl Street, Suite B-4
Tacoma, WA 98406
www.besttacomadentist.com

Changes for 2015 on how we collect Patient Portions and Insurance Calculations.

Due to the vast changes with the implementation of the Affordable Health Care Act (ACA), we have made necessary adjustments to our office protocol on how we calculate our patient's out-of-pocket portions for dental care and how this impacts you.

We now use a "standard formula" across the board for all insurances (100/80/50) and patient portions will be collected based on this "standard formula". All differences in collected payment portions which are collected at the time of service will become due in full when the final insurance payment has been received by our office.

This "standard formula" does not necessarily match your particular insurance coverage as it is impossible to speculate in regards to an insurance contract that is held between you and your employer or insurance carrier. Therefore, the responsibility is yours to know your coverage and be prepared to pay your out of pocket costs at a time of service and all residual balances in full upon receipt of billing statement from our office once your insurance carrier has paid us for services rendered.

All balances will be your responsibility regardless of insurance coverage or non payment.

Patient Name: _____ Patient Signature: _____ Date: _____

Are you familiar with your Dental Insurance Plan?

With the constant insurance changes, we *encourage you to become familiar with your dental benefits.* Please understand that no plan is a pay all. Dental insurance is meant to be an aid to help functionally restore the mouth to sound dental health. It must be considered only as a subsidy for reconstructive dentistry.

Your dental insurance is based upon a contract made between your employer and an insurance company. Many routine dental services are not covered by insurance companies. Necessary treatment may not be a covered benefit. It is also important for you to know that a procedure that was once covered may not always be covered. Treatment plans are determined by your doctor's diagnosis of treatment needed, NOT by insurance covered.

What does allowable amount mean? Insurance seldom pays 100% of what providers charge anymore. The "Allowable Amount" is the fee that an insurance company will pay for a given service. Sometimes the allowable amount is based on a negotiated "Fee Schedule". Sometimes, it is based on the "Usual and Customary Charge" for providers in a given geographic area. You may receive a statement with a residual balance after insurance pays as we do not know the allowable amounts for all insurance companies.

You will be asked to pay an ESTIMATED patient portion at the time of service. Your total account responsibility can only be determined after all insurance payments or denials have been received.

Patient Name: _____ Patient Signature: _____ Date: _____