WELCOME TO GENTLE DENTISTRY

Name_________________________________ Preferred Name_____________

Address____Apt #_________

City/State_____________________________Zip___________________

Home#__________________ Cell#__________________Work#_____________________

Email_____________________________________

Occupation____________________ SS#__________________DOB_________________

Dental Insurance Company____

Subscriber Name______________________________DOB_______________________

ID#_________________________Group#_____________________________________

Employer____

How did you hear about us?

___Google ___Yelp ___Facebook ___Referred By_________________________

Purpose of your visit____

Are you under a Doctors care?__________ For what reason_____________________

Doctors Name_________________________Phone#__________________________

Do you have or have you ever had:

___Rheumatic Fever	___Tuberculosis	___Epilepsy
___Heart Murmur	___Asthma	___Hepatitis
___Pacemaker	___Emphysema	___Blood Transfusion
___Artificial Joint	___Diabetes	___HIV
___Transplant	___Thyroid	___AIDS
___High Blood Pressure	___Glaucoma	___IV Drugs
___Heart Disease	___Chemotherapy	___Arthritis
___Alcohol Addiction	___Radiation	___Venereal Disease
___Latex Allergy	___Bleeding Problems	___Cancer
___Stroke	___BOTOX/Juvederm	___ Pregnant

If yes to the above, please explain____

Please list medication allergies____

Please list current medications____

Signature____ Date_________________

PATIENT DENTAL HISTORY

When was your last dental visit?_______________________________________

Have you enjoyed your past experiences?________________________________

Are you happy with your past dental treatment?___________________________

Do you have a history of the following: If so when?

Oral Surgery____

Periodontal Treatment_________________________________

Orthodontic Treatment_________________________________

What motivates you most to keep your teeth?

___Ability to chew ___Ability to speak ___Appearance

Other____

What is your present oral hygiene program? I brush ____ times a day

I floss ____ times a day

Are you experiencing any dental discomfort or have any present concerns?

____

Are you concerned with:

___Bleeding Gums	___Sensitivity to Hot	___Clenching/Grinding
___Bad Breath	___Sensitivity to Cold	___Tired Jaw
___Loose Teeth	___Sensitivity to Sweets	___Your Bite

ANGELA T. RASMUSSEN, DDS, FAGD

AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

As part of your healthcare, this practice originates and maintains paper and/or electronic records describing your health history, symptoms, examinations, test results, diagnoses, treatment, any plans for future care or treatment and payment for the services or treatment we provided. We use this information to:

- Plan your care and treatment
- Communicate with other health professionals or entities who contribute to your healthcare
- Submit your diagnosis and treatment information for payment for the services or treatment provided to you

"ONLY AS PERMITTED OR REQUIRED BY FEDERAL OR STATE LAW", WE MAY USE YOUR PROTECTED HEALTHCARE INFORMATION TO DO THE FOLLOWING:

- To disclose, as may be necessary, your health information (including HIV+/AIDS status, drug/alcohol abuse/dependency notes and qualified mental health notes) to other healthcare providers and healthcare entities (such as: referrals to or consultation with, other healthcare professionals, laboratories, hospitals, etc.) or to others as may be required by law or court order concerning your treatment, payment and/or healthcare.

- To request from other healthcare entities and/or healthcare providers (i.e. doctors, dentists, hospitals, labs, imaging centers, etc.) specific healthcare information we may need for planning your care and treatment.

- To submit the necessary information to your insurance company(s) for coverage verification as well as the diagnosis and treatment information to your insurance company(s), other agencies and/or individual(s) for payment of our services or treatment we provided to you.

- To leave appointment reminders or other minimum necessary information related to your healthcare or healthcare payments on an your answering machine, mobile voice or text mail, email or with a household family member.

  [ ] Please check here if you do not want us to leave messages on your answering machine or with a household family member.

  [ ] Please check here if you do not want us to leave a voice/text message on your mobile device.

  [ ] **Please check here if you authorize us to send your healthcare information by email. Please understand that email may be an unsecured medium of transmission and is potentially accessible by others. In addition to checking the box, we reserve the right to require you to authorize in writing the transmission of your healthcare information to you by unsecured email.**

- To discuss your health or payment information (only the minimum necessary in our judgment) with family members or other persons who are or may be involved with your healthcare treatment or payments.

- If you choose, please list by name and relationship the persons with whom we may share your healthcare or payment information____
  ____

- You may request a copy of and you have the right to read our "*Notice of Patient Privacy Practices*" prior to signing this authorization. The NPP provides a more complete description of health information uses and disclosures.

I fully understand and agree to this authorization and acknowledge the above rights and disclosures.

Patient Name (please print):____

______________________________ __________________________________

Signature | Print name of person signing if other than patient | Date

*If other than patient is signing, are you the parent, legal guardian, legal custodian or have a **Healthcare Power of Attorney** for the patient. Yes [ ] No [ ] RELATIONSHIP____

FOR OFFICE USE ONLY

Patient refused to sign the form. Reason:

____Date: __________________

GENTLE DENTISTRY

AUTHORIZATION FOR THE USE OF PHOTOGRAPHY AND TESTIMONIALS

In connection with the healthcare services that I, (patient name)____, have received or shall be receiving, do hereby authorize photography (using current and accepted methods) may be taken of me or parts of my body (as defined by my healthcare provider), under the following conditions:

1. **My healthcare provider may take the photography or it maybe taken by a designee approved by my healthcare provider who has signed a HIPAA required Business Associate Agreement with my healthcare provider.**

2. **The photography shall be used for medical records and if, in the judgment of my healthcare provider, medical research, education or science will be benefited by it's use, such photography and information relating to my case may be published and republished, either separately or in connection with each other, in professional journals or medical books, or used for any other purpose which he/she may deem proper in the interest of medical education, knowledge and research. It is specifically understood that in any such publication or use, all reasonable effort will be made so that I shall not be identified by name. I understand I may be recognized and identifiable in the photography. All reasonable efforts will be made to avoid personal identification.**

3. **I authorize my healthcare provider to use or re-use for marketing purposes, testimonials or photographs posted by me on social media (such as FACEBOOK, TWITTER, etc.). [ ] PLEASE CHECK**

4. **I authorize my healthcare provider to use for marketing purposes, photographs taken of or testimonials given by me or by my legal representative, only after discussing how they will be used. [ ] PLEASE CHECK**

5. **I understand the authorizations for numbers (3) and (4) above may be posted on the providers social media outlets, the providers website or used as directed by my healthcare provider. This information will be used only in a professional and ethical manor as directed by my healthcare provider. I have the right to request that my healthcare provider inform me prior to using any information for marketing or non-healthcare related purposes.**

6. **I authorize my healthcare provider to send information to me, either electronically or through a mail service, about products or services the practice may now or in the future provide that may be of interest to me.**

7. **I understand I have the right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization, or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, we must receive the revocation in writing. The revocation must include:**
   - **The patient's full name and address**
   - **The patient's desire to revoke this authorization**
   - **The effective date of this revocation**
   - **The patient's and/or patient's agent/representative's signature**
   - **The relationship to the patient, if applicable**

****We will accept written revocations of this authorization by Certified U.S. mail only.**

This Authorization shall be non-expiring except as listed below.

If this authorization is to be used solely for marketing purposes, then this authorization shall expire on: DATE___________________________________. After this date, we will no longer use or disclose your protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

______________________________	______________________________
Patient's Signature	**Patient's Agent/Representative's Signature & Relationship**
______________________________	______________________________
Signature of Witness	**Date**

ORAL HEALTH RISK FACTORS

Patient Name____

1. **Do you smoke or have you EVER smoked?** Yes/No

The amount you presently smoke?

An occasional cigarette___Less than 1 pack of per day___2 or more packs of per day___

An occasional cigar___Cigars on a daily/regular basis___A pipe on daily/regular basis___

How many years did you smoke?

Less than 2 years ago___ 2-5 years ___ 5-10 years___ 10-20 years___ 20+ years ago___

If you quit smoking, when did you quit?

Less than 6 months ago___ 6 months to a year ago___ 1-3 years ago___ 20+ years ago___

2. **Do you or have you EVER chew/chewed tobacco or used snuff?** Yes/No

If yes, how many years have you been using?

Less than 1 year___ 1-2 years___ 2-5 years ago___ 5+ years ago___

If you did in the past, but quit, how long ago?

Less than 6 months ago___ 6 months to a year ago___ 1-3 years ago___ 3+ years ago___

3. **Approximate average amount of alcoholic beverages consumed per week?**
   None___ 1-5___ 6-11___ 11-20___ 20+ plus___
4. **Do you have or have you ever have a substance abuse problem?** Yes/No
   Describe____
5. **Do you presently use any recreational drugs?** Yes/No
   List____
6. **Do you have or have you ever had an eating disorder?** Yes/No
   If yes, please specify______________________________________
7. **Do you have or have you ever had head, neck, or mouth piercings?** Yes/No
   List (other than pierced earrings)____
8. **Do you have or have you ever been informed that you have been infected with an oncogenic strain of the Human Papillomavirus (HPV)?** Yes/No
9. **List any family history of cancer?**
   ____

To the best of my knowledge all of the preceding information is correct and if there is ever any change in health, or medications this practice will be informed of the changes. I also consent to allow this practice to contact any healthcare provider(s) and to have my (or the patients) health information released to aid in care and treatment. I hereby consent to allow diagnosis, proper health care, and treatment to be performed by this practice until future notice.

I understand that there are no guarantees or warranties in health or dental care.

Signature____Date____________________________
(Parent or Guardian, if patient is a minor)
Reviewed By____Date____________________________

GENTLE DENTISTRY FINANCIAL POLICY

All charges are ultimately your responsibility regardless of your insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.

Your insurance policy is a contract between you, your employer, and the insurance company. Our office is not a party to that contract.

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility. We desire to make your dental treatment attainable, therefore, we offer the following payment options:

- **Payment In Full:** Pay in full and receive a 5% courtesy for treatment $5000.00 or more.
- **50/50:** This would allow you to pay full treatment in two visits (treatment plan must require two or more appointments). Treatment must be greater than $1500.00.
- **Care Credit:** 6 or 12 months interest free financing for qualified patients (monthly plan will depend on treatment plan total).
- **Well Fargo:** Flexible, special financing for qualified patients.
- **Dental Savings Plan:** For those without insurance, we offer our in office discount plan. Please ask one our our staff members for more information.
- **In Office Financing:** Interest free up to three month for treatment plans over $1500.00. A credit card must be kept on file for automatic monthly withdrawals.

Visa, MasterCard, American Express and Discover Accepted

BROKEN APPOINTMENT: Your appointment time is reserved exclusively for you and changes effect many patients. We make every effort to be punctual and ask the same of you. If you are unable to keep an appointment, we ask that you kindly given our office 48 hours notice.

A fee may be assessed for cancellations without prior notice.

Patient Signature______________________________Date____________

BROKEN APPOINTMENT POLICY

We understand that there will be times when you may miss an appointment due to an emergency or an unexpected obligation. However, when you do not call to cancel in advance or simply do not show for an appointment, that not only effects our schedule, but effects many patients.

We consider a “Broken Appointment” to be:

- **When a patient no shows for an appointment without prior notice.**
- ***When a patient cancels with less than 24 hours notice.**
- ***When a patient shows up 20 minutes past the appointment time.**

We make every effort to be punctual and we ask the same of you. If you are unable to keep an appointment, we typcially ask that you kindly give our office a 48 hours notice. For any “Broken Appointments” a fee may be charged to your account.

If you have any questions regarding our policies, please feel free our staff.

Thank you for your understanding,

Dr. Angela Rasmussen
Gentle Dentistry

*”Broken Appointment” fee is per our discretion and based on length and complexity of the appointment.

*Patients arriving more than 20 minutes late for an appointment may need to be rescheduled and may be considered as a “Broken Appointment” per our discretion.

Initial_________Date______________