Badger Mountain DENTAL

DR. LARRY BRAITHWAITE, DMD
FAMILY & COSMETIC DENTISTRY

GIVING FAMILIES A REASON TO SMILE!

www.badgermountaindental.com
509.578.1200

482 KEENE RD.
RICHLAND, WA 99352

WELCOME TO OUR OFFICE ~ WE LOOK FORWARD TO GETTING TO KNOW YOU

Date:

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐ OR REFERRED _____ ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

Patient Date of Birth: Patient SSN:

ADDRESS LINE 2

HOME:
CELL:
TEXT OK?:

CITY ST ZIP CODE

E-Mail:

Referral? ☐Yes ☐ No Whom may we thank for referring you:

EMERGENCY CONTACT

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

DENTAL HISTORY / INSURANCE INFORMATION

Previous Dentist/clinic: Reason for change:

☐Y☐N Dental Insurance? (☐ Self) Subscriber Name and DOB

☐Y☐N Are you currently having dental discomfort? If yes, explain:

☐Y☐N Are your teeth sensitive? ☐to cold ☐to hot ☐to sweets ☐when biting

What factors are most important for your satisfaction with our office?

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (Updated 2015)

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

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.

Signature: _____ **Date:**_____

☐ I give permission for the following communications to be used by Dr. Lawrence Braithwaite **(please check all that apply)** :
☐ Cell phone: ☐Text Message reminders permitted ☐ E-Mail: ☐ Home phone ☐ Work

☐ I am granting permission for Dr. Lawrence Braithwaite to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back ☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children as well:

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MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR PRIMARY PHYSICIAN:

☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX	☐BULIMIA	☐HEART ATTACK	☐PSYCHIATRIC TREATMENT
☐ADHD	☐CANCER/MALIGNANCY	☐HEART DISEASE	☐RADIATION/CHEMO
☐AIDS/HIV	☐CEREBRAL PALSY	☐HEART MURMUR	☐RESPIRATORY DISEASE
☐ANEMIA	☐CHEMICAL DEPENDENCY	☐HEPATITIS	☐RHEUMATIC FEVER
☐ANOREXIA	☐CONVULSIONS	☐HIGH BLOOD PRESSURE	☐SINUS PROBLEMS
☐ANXIETY	☐DEPRESSION	☐KIDNEY DISEASE	☐STROKE
☐ARTIFICIAL HEART VALVE	☐DIABETES	☐LIVER PROBLEMS	☐THYROID CONDITION
☐ARTIFICIAL JOINTS	☐DIZZINESS/FAINTING	☐MITRAL VALVE PROLAPSE	☐TUBERCULOSIS
☐ARTHRITIS	☐EPILEPSY/SEIZURES	☐MONONUCLEOSIS	☐ULCERS
☐ASTHMA	☐FREQUENT EAR INFECTIONS	☐PACEMAKER	
☐AUTISM/ASPERGER'S	☐ FREQUENT HEADACHES		
☐BLEEDING DISORDER	☐HEARING PROBLEMS	☐OTHER – PLEASE LIST:	

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN	☐CODEINE	☐LACTOSE INTOLERANCE	☐SLEEPING PILLS	☐NONE
☐ANESTHETIC – LOCAL	☐DAIRY	☐METAL SENSITIVITY	☐SULFA DRUGS	
☐BARBITURATES	☐LATEX	☐NITROUS OXIDE SEDATION	☐PENICILLIN/AMOXICILLIN	
☐OTHER – PLEASE LIST:				

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS	☐ANTIHISTAMINES/ALLERGY	☐DAILY ASPIRIN	☐BLOOD PRESSURE MEDICATIONS
☐BLOOD THINNERS	☐CANCER/CHEMO MEDICATIONS	☐CORTISONE/STEROIDS	☐HEART MEDICATION/DIGITALIS
☐INSULIN	☐NITROGLYCERIN	☐ORAL CONTRACEPTIVES	☐OSTEOPOROSIS MEDICATIONS
☐OTHER DIABETIC MEDICATIONS	☐RECREATIONAL DRUGS	☐THYROID MEDICATIONS	☐TRANQUILIZERS
☐OTHER (PLEASE LIST BELOW)			

DRUG NAME (OR WE CAN COPY YOUR LIST)	DOSAGE	REASON PRESCRIBED

☐ **SEE ATTACHED MED LIST**

PHARMACY NAME _____ PHARMACY PHONE NUMBER _____

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Financial Guidelines

We are grateful you allow us to care for you and are committed to providing you with exceptional care. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance and Assignment of Benefits (necessary to bill insurance in your behalf)

We accept all major dental insurances including Delta Dental, Cigna, Aetna, Assurant, United Concordia, Lincoln, Guardian, GEHA, Blue Cross Blue Shield, Assuris, Sun Life, and more.

No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

I certify that I, and/or my dependent(s), have insurance coverage with _____ insurance and assign directly to Badger Mountain Dental all insurance benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Badger Mountain Dental may use my health care information and may disclose such information only to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Payments

- **As you know, dental insurance does not always cover the cost of all treatment. For your convenience, we offer the following payment options:**
  - Cash, check, and all major credit cards are accepted (Visa, MasterCard, Discover)
  - Courtesy Discount for our uninsured cash/check paying patients
  - Care Credit Monthly Payment Plan (This is a line of credit which is used for health care expenses. They have NO interest 6 or 12 month options depending on the total.)
- **Balances left over 90 days can incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Appointment Confirmations/Short Cancelled/ Missed Appointments

- We make every attempt to confirm your scheduled appointments. **We ask that you please confirm your appointment** via phone, text, or email at least 24 hours prior to your scheduled appointment time. We reserve the right to cancel unconfirmed appointments after multiple attempts at confirmation have been made with no response.
- **Short notice canceled (under 24 hours notice) or missed appointments** will be charged $50 per appointment.
- **By signing below I acknowledge I have read and understand the guidelines above.**

Signature: _____ Date: _____