KELCEY RHODES, DDS
and ASSOCIATES
tel 253.845.0520 fax 253.770.8643

Main Station
DENTAL

111 West Main Street
Puyallup, WA 98371
scheduling@mainstationdental.com

PATIENT NAME_____ TODAY'S DATE____/____/____
First Last Middle

PATIENT ADDRESS_____
Street City State Zip

HOME PHONE_____ MOBILE PHONE_____ WORK PHONE_____

EMAIL ADDRESS: _____

PATIENT BIRTHDAY____/____/____ AGE_____ GENDER [ ] Male [ ] Female SOCIAL SECURITY #_____

PATIENT EMPLOYER_____ PATIENT OCCUPATION_____

PATIENT'S MARITAL STATUS [ ] Single [ ] Married Spouse's Name_____

PATIENT'S RELATIONSHIP TO PERSON PRIMARILY RESPONSIBLE FOR PAYMENT [ ] SELF [ ] SPOUSE [ ] CHILD [ ] Dependent

Whom may we thank for REFERRING you? [ ] Drive-by [ ] another Patient_____ [ ] Internet [ ] Local Paper_____ [ ] Other_____

EMERGENCY CONTACT (a local friend or relative)_____

CONTACT'S PHONE NUMBERS_____ RELATIONSHIP TO YOU_____

PRIMARY RESPONSIBLE PARTY TO PAY FOR PATIENT'S DENTAL SERVICES & TO RECEIVE BILLING STATEMENTS

NAME_____ RELATIONSHIP TO PATIENT [ ] SELF OTHER_____
MARITAL STATUS [ ] Single [ ] Married GENDER [ ] Male [ ] Female

ADDRESS_____ HOME PHONE_____

_____ WORK PHONE_____

City State Zip SOCIAL SECURITY #_____

BIRTHDAY____/____/____ EMPLOYER_____ OCCUPATION_____

EMPLOYER'S ADDRESS_____
Street Address City State Zip

DENTAL INSURANCE INFORMATION (if applicable)

**** NOT a Medicare Provider ****

INSURANCE COMPANY_____

EFFECTIVE DATE_____ PHONE_____

INSURANCE ADDRESS_____

_____
City State Zip

SUBSCRIBER'S NAME_____

____/____/____ _____
Subscriber's Birthdate Subscriber's Social Security Number

_____ _____
GROUP NUMBER Subscriber's ID Number

RELATIONSHIP TO SUBSCRIBER [ ] Self [ ] Spouse [ ] Child [ ] Dependent

SUBSCRIBER'S EMPLOYER_____

_____

2NDARY INSURANCE CO._____

EFFECTIVE DATE_____ PHONE_____

ADDRESS_____

_____
City State Zip

SUBSCRIBER'S NAME_____

____/____/____ _____
Subscriber's Birthdate Subscriber's Social Security Number

_____ _____
GROUP NUMBER Subscriber's ID Number

RELATIONSHIP TO SUBSCRIBER [ ] Self [ ] Spouse [ ] Child [ ] Dependent

SUBSCRIBER'S EMPLOYER_____

_____

Please sign the other side➔➔➔

PAYMENT OPTIONS

Our goal is to provide our patients with the finest and most comprehensive dental care possible. We will work with you to create the best treatment plan that fits within your financial expectations.
We will clearly explain your treatment options and give you a written financial estimate. Any changes in treatment or fees will be discussed as it occurs.
Payment is due at the time service is performed, unless arrangements have been made in advance.

Payment for your dental treatment is due at the time of treatment. We understand that some patients may not be able to (or may not desire to) pay cash for their treatment. Therefore, we offer several different payment types for your convenience to pay for your treatment.

1) Cash or Check
2) Visa or MasterCard
3) Care Credit Financing (no interest option, approval required by CareCredit)
   - If interested, please ask for an application.

MISSED APPOINTMENT FEES, INTEREST & LATE CHARGES, NSF CHECK FEES

I acknowledge that a $75 charge will be assessed for each hour of a missed appointment not cancelled 48 business hours in advance. I also acknowledge that a late charge of 1.5% per month, at a rate of 18% per year, with a minimum charge of $1.00 per month, will be charged on all unpaid account balances that are 30 days past due. I also acknowledge that a $25 charge will be assessed for any "NSF" checks (i.e., checks not paid by my bank due to non-sufficient funds or for "stop payment"). I realize that failure to keep my account current in payment will result in this office being unable to provide me additional dental services. In the case of this account being sent to a collection agency for a past due balance, I agree to pay all collection agency costs, reasonable attorneys fees, and legal expenses incurred to collect such past due balance.

AUTHORIZATION, RELEASE, AND ACKNOWLEDGEMENT OF FINANCIAL POLICY

1. I authorize your office to release any information related to my dental treatment, including any diagnosis and records or x-rays of any treatment or examination rendered to me during the period of such dental care to any third party payors, insurance companies, and/or other health and dental practitioners.

2. I authorize and request my insurance company, if any, to pay directly to your office the insurance benefits otherwise payable to me. I understand that your office is providing a courtesy to me by allowing me to assign my insurance benefits to your dental office, and that your office may terminate this courtesy at any time.

3. I understand that my dental insurance company and/or my primary responsible party may pay less than the actual bill for services. I agree to be solely responsible for full payment of all services rendered on my behalf or on behalf of my dependents should for any reason my insurance company and/or my primary responsible party fail to pay or pay less than full for such services.

4. I acknowledge that I have reviewed your office's Financial Policy.

5. I understand that Main Station Dental is NOT contracted with Medicare.

X _____ _____

Signature of Patient (or Signature of Parent/Guardian if a minor patient) Date

THANK YOU for filling out this form completely and reviewing our above office policies. The information you have provided will help us serve you dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

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PATIENT DENTAL HISTORY

PATIENT'S NAME_____DATE OF BIRTH_____
REASON FOR THIS VISIT_____
WHEN WAS YOUR LAST DENTAL VISIT_____WHAT WAS DONE THEN_____
PREVIOUS DENTIST (NAME ANDLOCATION) _____
HAVE YOU HAD A COMPLETE SERIES OF DENTAL XRAYS TAKEN? _____WHEN AND WHERE_____
HOW OFTEN DO YOU BRUSH YOUR TEETH_____HOW OFTEN DO YOU FLOSS YOUR TEETH? _____
IS YOUR DRINKING WATER FLUORIDATED? _____

DO YOUR GUMS BLEED WHEN YOU BRUSHING OR FLOSSING	YES	NO
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	YES	NO
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	YES	NO
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	YES	NO
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	YES	NO
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	YES	NO
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOU JAW?	YES	NO
CLICKING PAIN (JAW, JOINT, EAR, SIDE OF FACE)		
DIFFICULTY OPENING OR CLOSING DIFFICULTY CHEWING		
DO YOU HAVE FREQUENT HEADACHES?	YES	NO
DO YOU CLENCH OR GRIND YOUR TEETH?	YES	NO
HAVE YOU NOTICED ANY LOOSE TEETH?	YES	NO
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	YES	NO
HAVE YOU EVER HAD PERIODONTAL TREATMENT (FOR GUM DISEASE)?	YES	NO
EVER WORN A BITE PLATE OR OTHER APPLIANCE?	YES	NO
HAVE YOU EVER HAD PROLONGED BLEEDING AFTER AN EXTRACTION?	YES	NO
DO YOU WEAR DENTURES OR A PARTIAL DENTURE?	YES	NO
DATE OF PLACEMENT_____		

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? _____

SLEEP QUESTIONNAIRE

HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA?	YES	NO
HAVE YOU EVER HAD AN OVERNIGHT SLEEP STUDY?	YES	NO
IF YES, WHEN?_____WHERE?_____		
DO YOU WAKE UP IN THE MORNING WITH A HEADACHE?	YES	NO
HAS ANYONE EVER TOLD YOU THAT YOU CLENCH OR GRIND YOUR TEETH?	YES	NO
DO YOU SNORE?	YES	NO
HAVE YOU EVER BEEN TOLD YOU GASP FOR AIR OR SUDDENLY STOP BREATHING WHILE SLEEPING?	YES	NO
DO YOU OR HAVE YOU USED A CPAP?	YES	NO
IF YES, HOW MANY NIGHTS PER WEEK?_____		
WHAT IS YOUR NECK SIZE?_____		
DO YOU WAKE UP REFRESHED MOST DAYS OF THE WEEK?	YES	NO
ARE YOU EXCESSIVELY TIRED DURING THE DAY?	YES	NO

Time 11:04 AM

Main Station Dental

Date 5/22/2019

Eaglesoft Medical History(Copy)

Patient Name:

Birth Date:

Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Have you ever had a serious head or neck injury?	Yes No	If yes
Are you taking any medications, pills, or drugs?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Are you on a special diet?	Yes No	
Do you use tobacco?	Yes No	
Do you use controlled substances?	Yes No	If yes
Do you ever have thoughts of suicide?	Yes No	
Do you drink alcohol? If yes, how often?	Yes No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Radiation Treatments	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Recent Weight Loss	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Renal Dialysis	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Rheumatic Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Rheumatism	Yes No
Arthritis/Gout	Yes No	Epilepsy or Seizures	Yes No	High Cholesterol	Yes No	Scarlet Fever	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hives or Rash	Yes No	Shingles	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Hypoglycemia	Yes No	Sickle Cell Disease	Yes No
Asthma	Yes No	Fainting Spells/Dizziness	Yes No	Irregular Heartbeat	Yes No	Sinus Trouble	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Kidney Problems	Yes No	Spina Bifida	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Leukemia	Yes No	Stomach/Intestinal Disease	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Liver Disease	Yes No	Stroke	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Low Blood Pressure	Yes No	Swelling of Limbs	Yes No
Cancer	Yes No	Glaucoma	Yes No	Lung Disease	Yes No	Thyroid Disease	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Mitral Valve Prolapse	Yes No	Tonsillitis	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Osteoporosis	Yes No	Tuberculosis	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Congenital Heart Disorder	Yes No	Heart Pacemaker	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Convulsions	Yes No	Heart Trouble/Disease	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Yellow Jaundice	Yes No						

Have you ever had any serious illness not listed above? Yes No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____