DATE_____

MR./MRS./MISS/MS. _____ _____

(PLEASE CIRCLE ONE) LAST NAME FIRST NAME MI HOME PHONE

_____ _____

CURRENT STREET ADDRESS CELL PHONE / CARRIER ☐ PERMISSION TO TEXT?

_____ _____

CITY STATE ZIP MAILING ADDRESS IF DIFFERENT

_____ ____ SINGLE
____ MARRIED
____ DIVORCED
____ SEPARATED
____ WIDOWED

_____ MARITAL STATUS
(PLEASE CHECK ONE)

E-MAIL ADDRESS ☐ PERMISSION TO EMAIL?

_____ _____ _____

PATIENT BIRTHDATE SOCIAL SECURITY NUMBER EMPLOYER (IF SELF EMPLOYED, PLEASE STATE NAME OF BUSINESS)

_____ _____ _____ _____

EMPLOYER ADDRESS (IF SELF EMPLOYED, EMPLOYER PHONE# POSITION HELD HOW LONG

EMERGENCY CONTACT :

NAME _____ RELATIONSHIP _____ CONTACT INFORMATION _____

PLEASE TELL US HOW YOU FOUND OUT ABOUT OUR OFFICE _____

IF PHONE BOOK WHICH ONE? _____

FINANCIAL INFORMATION

_____ _____

NAME OF PERSON RESPONSIBLE FOR THIS ACCOUNT RELATIONSHIP

_____ _____ _____ _____ _____

CURRENT STREET ADDRESS CITY STATE ZIP HOME PHONE

ARE OTHER FAMILY MEMBERS PATIENTS IN OUR OFFICE? ____ ____ _____ _____

YES NO SOCIAL SECURITY NO. WORK PHONE

DENTAL INSURANCE INFORMATION

_____ _____ _____

INSURED PERSON'S FULL NAME (INCLUDING MIDDLE INITIAL) DATE OF BIRTH RELATIONSHIP TO PATIENT

_____ _____ _____

SOCIAL SECURITY NUMBER INSURANCE COMPANY NAME GROUP NUMBER

_____ _____ _____

UNION OR LOCAL NUMBER EMPLOYER NAME FULL ADDRESS OF EMPLOYER

_____ ____ ____

DO YOU HAVE SECONDARY DENTAL COVERAGE YES NO (IF YES, COMPLETE THE FOLLOWING)

_____ _____ _____

INSURED PERSON'S FULL NAME (INCLUDING MIDDLE INITIAL) DATE OF BIRTH RELATIONSHIP TO PATIENT

_____ _____ _____

SOCIAL SECURITY NUMBER INSURANCE COMPANY NAME GROUP NUMBER

_____ _____ _____

UNION OR LOCAL NUMBER EMPLOYER NAME FULL ADDRESS OR EMPLOYER

FOR ALL PATIENTS

I hereby authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with my dental care and further authorize and consent that the doctor chooses and employes such assistance as he deems fit. I also understand that previous to treatment, full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office, including any portion not covered by insurance. We require 24 hours notice for any appointment change. After a missed appointment their may be a $45.00 Fee charge to your account. Thank you.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY DATE

PATIENT INFORMATION

PATIENT'S NAME_____
Last First Initial Date of Birth

1. Purpose of initial visit _____
_____
2. Are you aware of a problem? _____
_____
3. How long since your last dental visit? _____
4. What was done at that time? _____
_____
5. Previous dentist's name _____
Address: _____ Tel. (___)_____
6. When was the last time your teeth were cleaned? _____

CIRCLE THE APPROPRIATE ANSWER

7. Have you made regular visits? ..... YES NO
How often? _____
8. Were dental x-rays taken? ..... YES NO
9. Have any teeth been removed? ..... YES NO
Why? _____
10. Have they been replaced? ..... YES NO
11. How have they been replaced?
a. Fixed bridge _____ Age _____
b. Removable bridge _____ Age _____
c. Denture _____ Age _____
12. Are you happy with the replacement? ..... YES NO
If no, explain_____
_____
13. Would you like to know about permanent replacements? ..... YES NO
14. Have you ever had any problems or complications with previous dental treatment? YES NO
If yes, explain _____
_____
15. Do you clench or grind your teeth? ..... YES NO
16. Does your jaw click or pop? ..... YES NO
17. Have you experienced any pain or soreness in the muscles or your face or around your ear? ..... YES NO
18. Do you have frequent headaches, neckaches or shoulder aches?..... YES NO
19. Does food get caught between your teeth? ..... YES NO
20. Are any of your teeth sensitive to hot _____cold_____sweets_____pressure _____
21. Do your gums bleed or hurt? ..... YES NO
When? _____
22. How often do you brush your teeth? _____When _____
23. Do you use dental floss? _____ YES NO
How often? _____
24. Are any of your teeth loose, tipped or shifted? ..... YES NO
25. Are you happy with the appearance of your teeth? ..... YES NO
26. How do you feel about your teeth in general? _____
_____
27. Do you feel your breath is offensive at times? ..... YES NO
28. Have you ever had gum treatment or surgery? ..... YES NO
What_____
Where _____
When _____
29. Have you had any orthodontic work? ..... YES NO
30. Have you had any unpleasant dental experiences or is there anything about dentistry that you strongly dislike? _____
31. Do you have any questions or concerns? ..... YES NO

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PATIENT'S SIGNITURE _____ DATE _____

DENTIST'S SIGNITURE_____ DATE _____

ANEST.

MED. ALERT

DENTAL HISTORY

PATIENT'S NAME _____

Last First Initial Date of Birth

CIRCLE THE APPROPRIATE ANSWER

1. Family Physician's Name_____
   Address_____
2. When was your last complete physical exam?_____
3. Are you taking any medications, vitamins or supplements?.....YES NO
   If so list _____
4. Are you allergic to any medications or substances?.....YES NO
   If so list _____
5. Do you have any other allergies?.....YES NO
   If so list _____
6. Do you have any sensitivities to penicillin, antibiotics, anesthetics or other medications?.....YES NO
   If so list _____
7. Are you sensitive to any metals or latex?.....YES NO
8. Are you pregnant or suspect you may be.....YES NO
   If so how many weeks? _____
9. What type of birth control do you use? Please list _____
10. Have you ever been treated for or been told you have heart disease?.....YES NO
    If so list _____
11. Do you have a pacemaker or an artificial heart valve implant?.....YES NO
    If so list _____
12. Do you have high or low blood pressure?.....YES NO
    If so which and list medications _____
13. Have you ever had a serious illness or major surgery?.....YES NO
    If so list date and type _____
14. Have you ever had radiation or chemotherapy treatment?.....YES NO
    If so list date and type _____
15. Do you have arthritis?.....YES NO
    If so list type and medications _____
16. Do you have any artificial joints / prosthesis?.....YES NO
    If so list date and type _____
17. Do you have any blood disorders, such as anemia, leukemia, etc?.....YES NO
    If so list _____
18. Do you have any stomach problems?.....YES NO
    If so list_____
19. Do you have any kidney problems?.....YES NO
    If so list _____
20. Do you have any liver problems?.....YES NO
    If so list _____
21. Are you diabetic?.....YES NO
    If so list type _____
22. Do you have asthma?.....YES NO
    If so list medications _____
23. Do you have epilepsy or seizure disorders?.....YES NO
    If so list type and medications _____
24. Do you have or have had a sexually transmitted disease?.....YES NO
    If so list _____
25. Have you tested HIV positive?.....YES NO
    If so when _____
26. Do you have any infectious diseases?.....YES NO
    If so list _____
27. Have you had or tested positive for hepatitis?.....YES NO
    If so list type and when _____
28. Do you or have you had T.B.?.....YES NO
29. Do you smoke tobacco?....YES NO How much? _____ For how long? _____
30. Do you chew tobacco?....YES NO List type_____ How much? ____ For how long? ____
31. Do you consume alcoholic beverages?.....YES NO
    If so how much? Daily _____ Weekly _____
32. Do you use controlled substances?.....YES NO
    If so list type and frequency _____
33. Have you had psychiatric treatment?.....YES NO
    If so list type and medications _____
34. Do you take medications for osteoporosis or osteopenia?.....YES NO
    If so list _____

COMMENTS

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

PATIENT'S SIGNATURE_____ DATE _____

DENTIST'S SIGNATURE_____ DATE _____

ANEST.

MEDICAL HISTORY

MED. ALERT

Moreno & Young Dental/Financial Policy

Dr Ronald Moreno, Dr John Young
3115 Howe Pl Ste 101, Bellingham, WA 98226 360-676-0642

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we require you read, agree to and sign prior to any treatment.

*All patients must complete our patient information forms before seeing the doctor.
**Full payment of the portion not covered by the insurance co. is due at time of service*.
*We accept cash, check, Debit,Visa/MasterCard, Discover Card or American Express.
*Additionally, we offer the option of Care Credit allowing the patient to have small payments over a period of time, in some cases 6,12, and 18 months same as cash with no interest charge.
*We confirm your appointment as a courtesy, but you are responsible to keep your appointment or give our office notice. **In the case of longer appointments, usually anything 90 minutes or longer, we require a deposit the day we schedule your appointment. In some cases we will ask to keep a credit card on file.**

Initial____**INSURANCE**

We are happy to submit your insurance claims if you provide us all the necessary information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. Our practice is committed to providing the best treatment possible for our patients and we charge what is usual and customary for our area. *You are responsible for paying the bill in full regardless of the insurance company's determination*. *We do our best to estimate your balance owing before insurance pays, please remember this is only an estimate and not a guarantee*. If you elect to have tooth colored filling on back teeth you might incur more out of pocket expense after your insurance pays. If you have seen another dentist, not in this office,. during your insurance benefit year, please, inform us. Or it may affect our patient out of pocket quote to you. Occasionally, insurance companies are slow to pay claims, to avoid interest charges from our office, you may want to pay the balance owing and receive a refund after the insurance company pays. We are no longer accepting patients receiving DSHS/Apple assistance. I am not receiving DSHS/Apple assistance and I agree to pay for services. If I become eligible for DSHS/Apple assistance, I agree to inform you at least 48 hrs. before treatment is rendered. At that time, we may not be able to see you as a patient.

Initial____**DELINQUENT ACCOUNTS**

We charge 1.5% interest after 60 days 18% apr. We also refer delinquent past due accounts to an outside collection agency. An account that is referred to a collection agency will result in termination of dental services from our office. We will be available for 30 days after the account is transferred to the collection agency for emergency care only. This is to allow the patient to find other dental care.

Initial____**MISSED APPOINTMENTS**

We require 48 hours notice for any appointment change or cancellation. There will be a charge of $45.00 per hour for Hygiene and $100.00 per hour for the doctor.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read, understand and agree to the above Financial Policy.

Patient or Responsible Party _____Date_____

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Moreno Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Moreno Dental reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ YES	☐ NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (Parents, Grandchildren)	☐ YES	☐ NO
Other: _____	☐ YES	☐ NO
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

Moreno Dental
3115 Howe Place, Suite 101 * Bellingham, Washington * 98226 * 360-676-0642

Moreno & Young DENTAL

Ronald A Moreno DDS
John D Young DDS
3115 Howe Place Suite 101
Bellingham, WA 98226
360-676-0642
Fax: 360-676-1418

Date:_____

I, _____ authorize Dr. _____ office to release my dental x-rays and other health care information to Moreno & Young Dental.

Thank you,

_____

Patient or authorized agent signature

_____

Date

Please forward x-rays to admin1@mydentalbellingham.com

Name	DOB	Date

This questionnaire was developed based upon the published findings of the American Academy of Sleep Medicine (AASM). The purpose of this questionnaire is to aid a qualified medical professional in identifying possible symptoms of a sleep disorder and is not meant to be used as a substitute for any diagnostic procedure.

Y / N	8	Have you ever been told you stop breathing while asleep?
Y / N	6	Have you ever fallen asleep or nodded off while driving?
Y / N	6	Have you ever woken up suddenly with shortness of breath, gasping or with your heart racing?
Y / N	4	Do you feel excessively sleepy during the day?
Y / N	4	Do you snore, or have you ever been told that you snore?
Y / N	2	Have you had weight gain and found it difficult to lose?
Y / N	2	Have you taken medication for, or been diagnosed with high blood pressure?
Y / N	3	Do you kick or jerk your legs while sleeping?
Y / N	3	Do you feel burning, tingling or crawling sensations in your legs when you wake up?
Y / N	3	Do you wake up with headaches during the night or in the morning?
Y / N	4	Do you have trouble falling asleep?
Y / N	4	Do you have trouble staying asleep once you fall asleep?
		Total Score

FOR CLINICAL USE ONLY

Low	Moderate	High	Severe
0-7	8-11	12-15	16+

Visual Indications

☐ Enlarged/Scalloped Tongue ☐ Retruded Lower Jaw ☐ High Arching Hard Palate ☐ Bruxism
☐ Gastroesophageal Reflux ☐ Enlarged Tonsils ☐ Mouth Breather

Have you ever been diagnosed with a sleep disorder? ☐ Yes ☐ No
Are you currently using a CPAP machine? ☐ Yes ☐ No (if yes) Do you use it every night? ☐ Yes ☐ No

Notes: