

Patient Intake Form

Welcome to our office. To assist us in serving you please complete the following forms. If you have any questions, don't hesitate to ask.

Patient Name	DOB	SSN
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Email Address

Mailing Address	City	State	Zip
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Previous Address (If less than 3 years)	City	State	Zip
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Home Phone	Cell Number
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Employer	Occupation	No. Years Employed
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Emergency Contact (Name and Phone Number)

Primary Insured's Name	DOB	SSN
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Insurance Company	Group Name/Number
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3100 NW Bucklin Hill Rd, Suite 209
Silverdale, WA 98383
(360) 633-2377
Lifelongdental1@gmail.com

Secondary Insured's Name

DOB

SSN

Insurance Company

Group Name/Number

How did you become aware of Dr. Gillespie?

Any additional information you would like to share?

I authorize Life Long Dental to take x-rays, models, photos, or other aides to perform necessary treatment, medication, or therapy.

I understand the use of anesthetic agents embodies certain risks. (Please ask Dr. Gillespie to explain this before treatment if you have questions.)

I understand that I am responsible for all fees regardless of whether insurance is involved or not. A credit report may need to be obtained prior to any financial agreement.

I authorize the release of any information pertaining to my insurance claims as well as payment of the dental benefits of this office.

Patient Printed Name

Parent or Legal Guardian Printed Name (If patient is under 18 years old)

Patient, Parent or Legal Guardian Signature

Date

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DENTAL HISTORY

Name _____ Nickname _____ Age _____
 Referred by _____ How would you rate the condition of your mouth? Excellent Good Fair Poor
 Previous Dentist _____ How long have you been a patient? _____ Months/Years
 Date of most recent dental exam ____/____/____ Date of most recent x-rays ____/____/____
 Date of most recent treatment (other than a cleaning) ____/____/____
 I routinely see my dentist every: 3 mo. 4 mo. 6 mo. 12 mo. Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ YES NO
2. Have you had an unfavorable dental experience? _____ YES NO
3. Have you ever had complications from past dental treatment? _____ YES NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ YES NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ YES NO
6. Have you had any teeth removed or missing teeth that never developed? _____ YES NO

GUM AND BONE



7. Do your gums bleed or are they painful when brushing or flossing? _____ YES NO
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ YES NO
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ YES NO
10. Is there anyone with a history of periodontal disease in your family? _____ YES NO
11. Have you ever experienced gum recession? _____ YES NO
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ YES NO
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth? _____ YES NO

TOOTH STRUCTURE



14. Have you had any cavities within the past 3 years? _____ YES NO
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ YES NO
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ YES NO
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ YES NO
18. Do you have grooves or notches on your teeth near the gum line? _____ YES NO
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ YES NO
20. Do you frequently get food caught between any teeth? _____ YES NO

BITE AND JAW JOINT



21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ YES NO
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ YES NO
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ YES NO
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ YES NO
25. Are your teeth becoming more crooked, crowded, or overlapped? _____ YES NO
26. Are your teeth developing spaces or becoming more loose? _____ YES NO
27. Do you have more than one bite, squeeze, or shift your jaw to make your teeth fit together? _____ YES NO
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____ YES NO
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ YES NO
30. Do you clench your teeth in the daytime or make them sore? _____ YES NO
31. Do you have any problems with sleep (i.e. restlessness), wake up with a headache or an awareness of your teeth? _____ YES NO
32. Do you wear or have you ever worn a bite appliance? _____ YES NO

SMILE CHARACTERISTICS



33. Is there anything about the appearance of your teeth that you would like to change? _____ YES NO
34. Have you ever whitened (bleached) your teeth? _____ YES NO
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ YES NO
36. Have you been disappointed with the appearance of previous dental work? _____ YES NO

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
 Name of Physician/and their specialty _____
 Most recent physical examination _____ Purpose _____
 What is your estimate of your general health? Excellent Good Fair Poor

	YES	NO		YES	NO
1. hospitalization for illness or injury _____	<input type="checkbox"/>	<input type="checkbox"/>	27. arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
2. an allergic reaction to _____			28. autoimmune disease _____ (i.e. rheumatoid arthritis, lupus, scleroderma)	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> aspirin, ibuprofen, acetaminophen, codeine			29. glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> penicillin			30. contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> erythromycin			31. head or neck injuries _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> tetracycline			32. epilepsy, convulsions (seizures) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> sulfa			33. neurologic disorders (ADD/ADHD, prion disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> local anesthetic			34. viral infections and cold sores _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> fluoride			35. any lumps or swelling in the mouth _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> metals (nickel, gold, silver, _____)			36. hives, skin rash, hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> latex			37. STI / STD / HPV _____	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> other _____			38. hepatitis (type _____) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. heart problems, or cardiac stent within the last six months _____	<input type="checkbox"/>	<input type="checkbox"/>	39. HIV / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
4. history of infective endocarditis _____	<input type="checkbox"/>	<input type="checkbox"/>	40. tumor, abnormal growth _____	<input type="checkbox"/>	<input type="checkbox"/>
5. artificial heart valve, repaired heart defect (PFO) _____	<input type="checkbox"/>	<input type="checkbox"/>	41. radiation therapy _____	<input type="checkbox"/>	<input type="checkbox"/>
6. pacemaker or implantable defibrillator _____	<input type="checkbox"/>	<input type="checkbox"/>	42. chemotherapy, immunosuppressive medication _____	<input type="checkbox"/>	<input type="checkbox"/>
7. orthopedic implant (joint replacement) _____	<input type="checkbox"/>	<input type="checkbox"/>	43. emotional difficulties _____	<input type="checkbox"/>	<input type="checkbox"/>
8. rheumatic or scarlet fever _____	<input type="checkbox"/>	<input type="checkbox"/>	44. psychiatric treatment _____	<input type="checkbox"/>	<input type="checkbox"/>
9. high or low blood pressure _____	<input type="checkbox"/>	<input type="checkbox"/>	45. antidepressant medication _____	<input type="checkbox"/>	<input type="checkbox"/>
10. a stroke (taking blood thinners) _____	<input type="checkbox"/>	<input type="checkbox"/>	46. alcohol / recreational drug use _____	<input type="checkbox"/>	<input type="checkbox"/>
11. anemia or other blood disorder _____	<input type="checkbox"/>	<input type="checkbox"/>	ARE YOU:		
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	<input type="checkbox"/>	<input type="checkbox"/>	47. presently being treated for any other illness _____	<input type="checkbox"/>	<input type="checkbox"/>
13. emphysema, shortness of breath, sarcoidosis _____	<input type="checkbox"/>	<input type="checkbox"/>	48. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	<input type="checkbox"/>	<input type="checkbox"/>
14. tuberculosis, measles, chicken pox _____	<input type="checkbox"/>	<input type="checkbox"/>	49. taking medication for weight management _____	<input type="checkbox"/>	<input type="checkbox"/>
15. asthma _____	<input type="checkbox"/>	<input type="checkbox"/>	50. taking dietary supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) _____	<input type="checkbox"/>	<input type="checkbox"/>	51. often exhausted or fatigued _____	<input type="checkbox"/>	<input type="checkbox"/>
17. kidney disease _____	<input type="checkbox"/>	<input type="checkbox"/>	52. experiencing frequent headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
18. liver disease _____	<input type="checkbox"/>	<input type="checkbox"/>	53. a smoker, smoked previously or use smokeless tobacco _____	<input type="checkbox"/>	<input type="checkbox"/>
19. jaundice _____	<input type="checkbox"/>	<input type="checkbox"/>	54. considered a touchy / sensitive person _____	<input type="checkbox"/>	<input type="checkbox"/>
20. thyroid, parathyroid disease, or calcium deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	55. often unhappy or depressed _____	<input type="checkbox"/>	<input type="checkbox"/>
21. hormone deficiency _____	<input type="checkbox"/>	<input type="checkbox"/>	56. FEMALE - taking birth control pills _____	<input type="checkbox"/>	<input type="checkbox"/>
22. high cholesterol or taking statin drugs _____	<input type="checkbox"/>	<input type="checkbox"/>	57. FEMALE - pregnant _____	<input type="checkbox"/>	<input type="checkbox"/>
23. diabetes (HbA1c = _____) _____	<input type="checkbox"/>	<input type="checkbox"/>	58. MALE - prostate disorders _____	<input type="checkbox"/>	<input type="checkbox"/>
24. stomach or duodenal ulcer _____	<input type="checkbox"/>	<input type="checkbox"/>			
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	<input type="checkbox"/>	<input type="checkbox"/>			
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) _____	<input type="checkbox"/>	<input type="checkbox"/>			

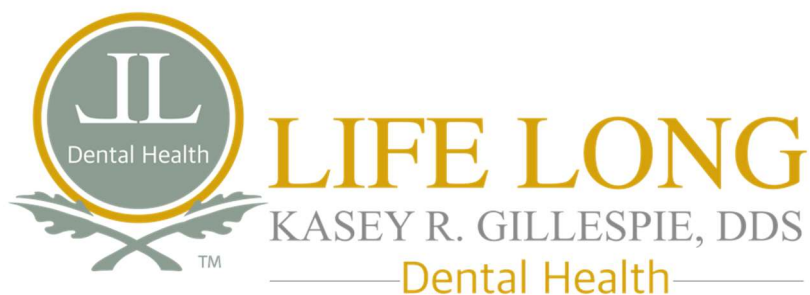
Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment.
 (i.e. Botox, Collagen Injections)

List all medications, supplements, and or vitamins taken within the last two years.

Drug	Purpose	Drug	Purpose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____
 Doctor's Signature _____ Date _____



Cancellation/No Show Policy

Appointment times are very important to our patients. When a patient fails to keep their appointment, this time goes unused. Even on a short notice, another patient could have made use of the appointment time. By implementing a "No Show" fee, it is our goal to maintain an effective and predictable schedule for the benefit of the patients and the practice.

If you fail to show for an appointment and/or do not give us a 48 hour notice prior, then a \$50.00 fee will be charged to your account. These charges will not be billed to your insurance provider.

Please notify us as soon as possible if you cannot make your scheduled appointment, so we can offer it to another patient. Your consideration is appreciated, in hopes that the sooner you call us the greater our chance is of providing our services to another patient in need.

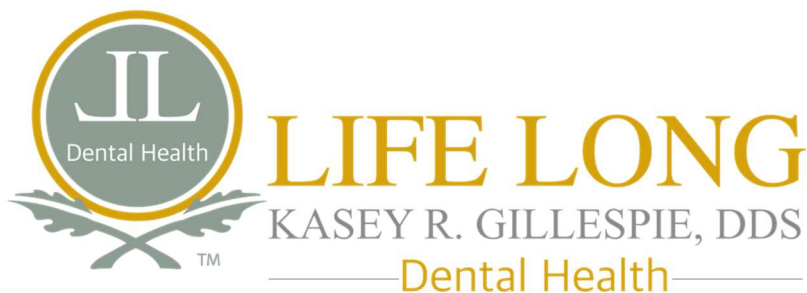
Patient Printed Name

Parent or Legal Guardian Printed Name (If patient is under 18 years old)

Patient, Parent or Legal Guardian Signature

Date

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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 Life Long Dental Health. 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.

Life Long Dental Health reserves the right to change the privacy practices that are 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 to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER (PLEASE SPECIFY)		YES		NO

Name of Patient or Legal Guardian	Patient or Legal Guardian Signature
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Date	Description of Legal Guardian
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OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained

Provided Prior to Treatment?		YES		NO
Date Provided:				

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Reason for Denial:		Need more time to review Statement of Privacy Practices
		Wanting to consult with another person before signing
		Unable to sign
		Reason not given
		Other (explain)

Statement of Privacy Practices (HIPAA)

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Person Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of WA This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone - even family members - without your written consent. You may give written authorization for us to disclose your information to anyone you choose.

Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, phone numbers, SSN, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

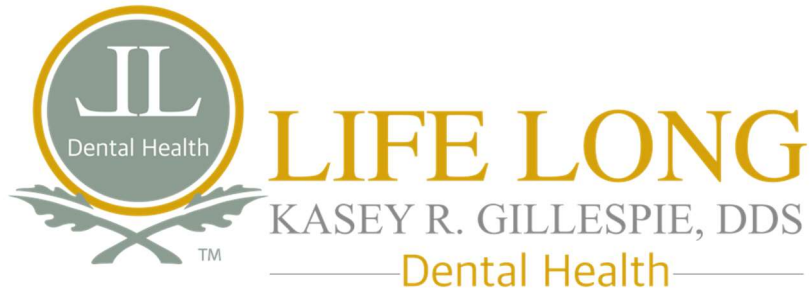
As stated above, we may disclose information as required by law. We are obligated to provide information for law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments, including voicemail messages and post cards.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than that stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Dept of Health and Human Services. Please ask if you have any questions about your privacy rights or the protection of your health information.

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Office Financial Agreement

The following policies have been prepared to help you understand the financial portion of your dental treatment. It is provided to help eliminate confusion and misunderstandings regarding necessary payment.

1. An estimate of fees and services for any treatment will be provided prior to treatment.
2. You are responsible for all charges. As a courtesy, we are currently filling out and submitting all necessary information and insurance forms. We estimate as closely as possible your cost share of treatment rendered. Your portion is due at the time of service unless arrangements have been made ahead of time.
3. Please ask if you have any questions regarding your treatment or charges.

We will be glad to answer any of your questions

I have read and accept the financial policies as explained above.

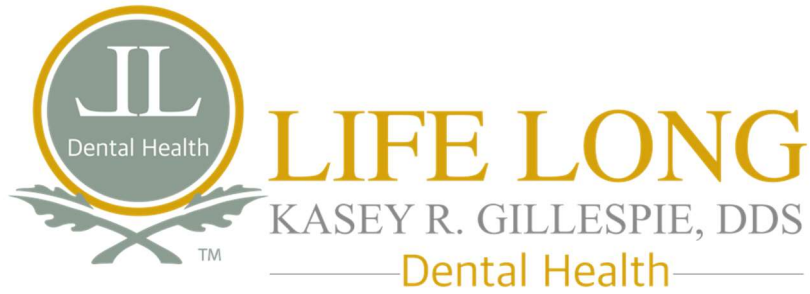
Patient Printed Name

Parent or Legal Guardian Printed Name (If patient is under 18 years old)

Patient, Parent or Legal Guardian Signature

Date

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Release of Dental Records

Patient Printed Name

Life Long Dental Health is authorized to provide any insurance company(s), claim administrator(s) or other healthcare professional's information regarding health care advice, treatment or diagnostic supplies. This information will be used for purpose of evaluation and administering claims or treatment for ongoing clinical services.

Please Send Records To

Phone Number

Email

This authorization is valid for two years.

I know I have right to receive a copy of this authorization upon request and agree that the photographic copy of this authorization is as valid as the original.

Parent or Legal Guardian Printed Name (If patient is under 18 years old)

Patient, Parent or Legal Guardian Signature

Date

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