Juanita Family Dentistry

Chelsea Mortell Petisme, DMD
13611 100th Ave NE
Kirkland WA 98034
Phone: 425.821.3388
www.juanitafamilydentistry.com

Adult Patient Registration

Today's Date _____

First _____ M. _____ Last _____

Address _____

Cell# _____ Home# _____

Work _____ DOB _____ SS# _____

Marital Status _____ Email _____

Employer _____ Occupation _____

Who may we thank for referring you? _____

Dental Insurance

Company _____ ID# _____

Subscriber Name _____ Sub Relationship to Patient _____

Sub Birth date _____

Sub SS# _____ Grp# _____

Sub Address _____

Emergency Information

Name of nearest relative not living with you _____

Relationship to patient _____ Cell# _____

Address _____

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 Chelsea D. Mortell Petisme. 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 the office with respect to my protected health information. Dr. Chelsea D. Mortell Petisme reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If they change I will be offered a copy of the revision and may request that it be mailed to me.

I herby specifically authorize disclosure of my protected health care information to the persons indicated: _____

I have filled in my information to the best of my ability and understand that it will be used to bill my dental insurance and to acknowledge receipt of the Notice of Privacy Practices.

Signature _____ **Printed Name** _____

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Medical History

Have you eve had a major operation including hospitalization?	Yes No	If yes	
Have you ever had a serious head or neck injury?	Yes No	If yes	
Please list any medications, pills, or drugs you are taking?	Yes No	If yes	
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes	
Do you use tobacco?	Yes No		

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

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	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	Asthma	Yes No	Fainting Spells/Dizziness	Yes No
Irregular Heartbeat	Yes No	Sinus Trouble	Yes No	Blood Disease	Yes No	Kidney Problems	Yes No
Blood Transfusion	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	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						

Are you interested in braces?	☐	If yes	
Are you presently in any dental pain?	☐	If yes	
Have you had your wisdom teeth removed?	☐	If yes	
Have you ever experienced any unfavorable reaction to dentistry?	☐	If yes	
Have you ever experienced chronic ringing in the	☐	If yes	
Do you get tension headsches?	☐	If yes	

Patient Name:_____ Date of Birth: _____

Signature: _____

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Office Agreement

We feel strongly that our patients deserve the best care. In an effort to provide high quality care, we would like to share our financial policy, insurance billing information and scheduling agreement with you to avoid future confusion.

We ask that you pay in full at each visit. As a courtesy to you we will bill your dental insurance company. The insurance contracts are between the patient and the insurance company; we cannot guarantee benefits. The patient is responsible to keep the office up to date on policy information, and any portion unpaid by the insurance company at the date of service. Any patient under the legal age of 18 is considered a minor. The parent or legal guardian is responsible for payment and treatment decisions.

I will be responsible for any financial obligations incurred in connection with dental treatment rendered in my or my child's behalf. I understand that full payment must be made at the time of service. I further understand that I am responsible for any charges that are not covered by my insurance. I will be subject to finance charges on unpaid balances after 30 days.

Please Initial_____

I understand that balances over 90 days will be sent to a third party collection agency including any of my personal information necessary to collect the balance owed. Any checks returned from my bank are subject to a $35 returned check fee.

Please Initial_____

We wish to give all our patients their preferred time and request you help us do that by making your appointments. Your time is important to us! We request 48 hours notice for cancelling or rescheduling. A $50 cancellation fee may be applied for missed or cancelled appointments.

I understand the above cancellation policy and agree to pay a broken appointment fee of up to $50 per scheduled hour without giving the requested notice.

Please Initial_____

We are now sending email and text reminders to confirm your appointments. Please list the cell phone number and email you would like your reminders sent.

Cell Phone_____**Email**_____

Signature_____**Relationship**_____

Printed Name_____**Date**_____