Welcome to Your New Practice!
Since you are new to our office, we would like to extend a warm welcome and introduce you to our general dentistry practice. It is our goal to see that you receive the best possible care to fit your own unique dental needs. We would be happy to answer any questions you have, no matter how small, and would like to keep you informed at every step of your treatment here with us.

Office Hours
The doctor and hygienists see patients Monday through Friday, 8A until 5P. Should you have an emergency, you can call the office to receive instructions on how to reach Dr. Dorsch after regular hours.

Appointments
When an appointment is made, a significant amount of time is set aside for you and the doctor or hygienist. We ask that you respect this time and to make every effort to keep your appointments. If you are unable to keep an appointment, kindly call our office and inform us at least 24 hours in advance. This allows us to fill the cancelled appointments with other patients requiring care. Typically we will call you to confirm your appointment two days in advance.

Financial Information
Unless you have insurance coverage, or have made prior arrangements with our front office, payment is expected on the day of treatment. A five percent courtesy cash discount is offered for full payment prior to or at the time of treatment. If you have insurance, we will file the necessary forms for payment. There will be a service charge for account balances over 30 days. We also have a program available through our office called Care Credit, which allows you to make small monthly payments for health care services. Ask our front office for details on payment options.

Should any of these points need clarification, or if you have any questions, please do not hesitate to ask our staff.

We look forward to seeing you soon!

Sincerely,

Mathew B. Dorsch, DDS

3400 Squalicum Pkwy., Ste. 107, Bellingham, WA 98225) 360 734 9926) CarrDorschDental.com

Medical History

Name:

Date:

Please answer the following questions as accurately as possible. This information is necessary in providing the best service to you and, of course, is confidential. Please let us know of any changes to information pertaining to your health, and we will update this form. Thank you! ***Mathew B. Dorsch,*** *DDS*

1. **Have you been under the care of a medical doctor within the past two years?** YES NO
   If yes, for what? *When?*
   Physician's name: *Phone:*
   Address: *City:* *Zip:*
2. **Have you taken any medications or drugs within the past two years?** YES NO
3. **Are you taking any medications, drugs or pills now, including aspirin and/or birth control pills?** YES NO
   If yes, please list the name and dosage:
4. **Have you ever taken medications for osteoporosis (Fosamax, Boniva, Actonel)?** YES NO
5. **Have you ever taken prescription medications for weight loss (diet pills)?** YES NO
6. **Are you aware of having an allergic (or adverse) reaction to any medication or substance, including metal?** YES NO
   If yes, what are you allergic to?
7. **Have you been a patient in the hospital during the past five years?** YES NO
8. **Do you use pillows to help position yourself in order to sleep?** YES NO
9. **Have you gained or lost more than ten pounds this year?** YES NO
10. **Women:** *Are you Pregnant?* YES NO *Nursing?* YES NO *Taking birth control pills?* YES NO
11. **Indicate which of the following you have had or are having at present:**

Condition			Condition			Condition		
Heart Problems:			Emphysema	YES	NO	Sickle cell anemia	YES	NO
✔ Heart Surgery	YES	NO	Chronic cough	YES	NO	IV drug use	YES	NO
✔ Heart Murmur	YES	NO	Tuberculosis	YES	NO	Drug addiction	YES	NO
✔ Heart Attack	YES	NO	Asthma	YES	NO	Blood transfusion	YES	NO
✔ Heart MVP	YES	NO	Hay fever	YES	NO	Liver disease	YES	NO
✔ Rheumatic fever	YES	NO	Latex sensitivity	YES	NO	Yellow jaundice	YES	NO
✔ Heart Disease	YES	NO	Sinus trouble	YES	NO	Neurologic disorder	YES	NO
✔ Pacemaker	YES	NO	Tumors	YES	NO	Seizure disorder	YES	NO
✔ Artificial heart valve	YES	NO	Leukemia	YES	NO	Fainting/dizziness	YES	NO
✔ Heart failure	YES	NO	Cancer	YES	NO	Epilepsy	YES	NO
✔ Heart Angina	YES	NO	Chemotherapy	YES	NO	Nervous anxiety	YES	NO
✔ Chest pain	YES	NO	Radiation therapy	YES	NO	Psychiatric care	YES	NO
High blood pressure	YES	NO	Hepatitis (A,B,C,D)	YES	NO	Restricted diet	YES	NO
Stroke	YES	NO	Herpes/Cold sores	YES	NO	Cortisone medicine	YES	NO
Diabetes	YES	NO	Venereal disease	YES	NO	Retinal surgery	YES	NO
Thyroid problems	YES	NO	HIV / AIDS	YES	NO	Swollen ankles	YES	NO
Glaucoma	YES	NO	Ulcers	YES	NO	Kidney troubles	YES	NO
Anemia	YES	NO	Hives	YES	NO	Artificial joints	YES	NO
Hemophilia	YES	NO	Allergies	YES	NO	Arthritis	YES	NO
Bruise easily	YES	NO	Tobacco use	YES	NO			

12. **Do you have, or have you had any disease, condition or problem not listed?** YES NO
    If so please list it here:

I understand the above information is necessary to provide me with dental care in a safe and effective manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of changes in my health or medication.

Patient/Guardian signature: **Date:**

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FOR OFFICE STAFF USE ONLY:

Initial exam date:	Comments:	
Date:	Changes:	Initials:
Date:	Changes:	Initials:
Date:	Changes:	Initials:
Date:	Changes:	Initials:
Date:	Changes:	Initials:
Date:	Changes:	Initials:
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Date:	Changes:	Initials:
Date:	Changes:	Initials:
Date:	Changes:	Initials:

Date:

Please answer the following questions as accurately as possible. This information is necessary in providing the best service to you and, of course, is confidential. If you have any questions, don't hesitate to ask. Thank you.

Mathew B. Dorsch, *DDS*

Patient name: DOB: Age: Sex:

If patient is a child, parent or guardian's name: Home phone:

SSN: Employer/Occupation: Work phone:

Email address: Please contact me by: Email ❑ Phone ❑ Both ❑

Emergency name / phone no. *(contact other than spouse)*:

Driver's license #: State: Spouse: Phone:

Home address: City: State: Zip:

Billing address (if different): City: State: Zip:

Present physician: Date of your last visit to medical doctor: Phone:

Previous dentist: City: State: Phone:

Date of last dental treatment: Date of last x-rays:

How did you hear about our office?:

Primary Dental Insurance, if Applicable

Insurance co. name: Address: City: Zip:

Subscriber's name: Address: City: Zip:

Subscriber's SSN: DOB: Employer:

Office phone number: Group number: Anniversary date:

Secondary Dental Insurance, if Applicable

Insurance co. name: Address: City: Zip:

Subscriber's name: Address: City: Zip:

Subscriber's SSN: DOB: Employer:

Office phone number: Group number: Anniversary date:

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Financial Policy

Payment in full is expected at the time of treatment. The patient or guardian is responsible for payment of services provided regardless of contracts with dental benefit plans. We will gladly pre-authorize treatment estimates with your benefit provider for major treatment. Our office is happy to accept your estimated copayment and bill your benefit provider for the remaining amount. If the actual insurance payment is less than the estimated payment, or if the claim is denied, your account will carry a balance for which you will receive a monthly statement. Accounts not paid in full within 30 days from statement billing will accrue a 1% fee per month not to exceed 12% annual.

The estimated insurance payment is not a guarantee of coverage, payment or authorization. Payment is subject to plan provisions, including deductibles, plan maximums and exclusions, fee schedules and patient eligibility at the time services are actually performed.

There are times when planned treatment becomes more extensive. You will be informed of these changes at the first available opportunity, including alternative treatment options and fees.

Payment Options

ZERO BALANCE: 5% courtesy for payment in full at the time of service.
MAJOR CREDIT CARDS: Visa, MasterCard, American Express.
CARE CREDIT: We can assist you in applying for credit for dental services through a program called ***Care Credit***. Ask our staff about this option.

Patient Name: ______________________________

Responsible Party: ______________________________

Statement of Understanding

I understand the financial arrangements and agree to comply with them. I agree that parents and guardians are responsible for all fees and services rendered for treatment of a child. I understand that I am responsible for all fees regardless of insurance coverage. I also understand that when treatment is rendered the fees may have to be adjusted, but that I will be informed of these adjustments. In the event that my payments are not received within 30 days of their due date that I will incur a 1% fee per month not to exceed 12% annual.

Responsible Party Signature: ______________________ **Date:** __________

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Acknowledgement of Receipt
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Acknowledgement Of Receipt Of Our "Notice Of Privacy Practices"
Notice of Privacy Practices: Law requires us to make a good faith effort to obtain your signature signifying you have been provided a copy of our Notice of Privacy Practices. You have the right to read our Notice of Privacy Practices before you decide whether to sign the Consent. Our Notice provides a description of our treatment, payment, health care operations, and the uses and disclosures we may make of your protected health information. It explains in detail the procedures we use to protect your health care and personal information. A full copy of our Notice of Privacy Practices accompanies this Consent. Please take the time to read it carefully and completely.

We reserve the right to revise our Privacy Practices at any time. If changes are made we will issue a revised copy of our Privacy Practices. These changes apply to any of your protected health information that we maintain.

I, ____, have reviewed a copy of this office's Notice of Privacy Practices.

Consent For Use And Disclosure Of Health Information
Purpose of Consent: By signing this form, you will consent to the use and disclosure of your protected health information to carry out treatment, payment activities, and health care operations by Dr. Mathew B. Dorsch and staff.

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation to our HIPAA compliance officer. Please understand that revocation of this Consent will NOT affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

I, ____, have had full opportunity to read and consider the contents of this Consent form and the Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature: Date:

If this Consent is signed by a personal representative on behalf of the patient, please complete the following:

Personal Representative's Name:

Relationship to Patient:

Office Use Only
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

❏ Individual refused to sign

❏ Communication barriers prohibited obtaining acknowledgement