J. Bayard DuBois, DDS, PS

We would like to welcome you to our office. Our goal is to make every patient's visit a pleasant and educational one. Our practice is based on preventive care. We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime!

1 PATIENT INFORMATION

Patient's Name: _____ (Last / First / MI)

I prefer to be called: _____

Home Address: _____ (Street / Apartment #)

_____ (City / State / Zip Code)

Home #: (____) _____ Cell #: (____) _____

Work #: (____) _____ Other #: (____) _____

When/where are the best times to reach you? _____

Employer _____

Occupation _____ How long there? _____

Who may we thank for referring you to our office? _____

Previous/Present Dentist: _____ (City/State)

Today's Date: _____

E-mail Address: _____

❒ Male ❒ Female

❒ Single ❒ Widowed

❒ Married ❒ Divorced

Birthdate: ____ /____ /____

Social Security # _____

Are you a Full Time Student? ❒ Yes ❒ No

2 INSURANCE INFORMATION

Primary Insurance

Insured's Name: _____

Relationship: _____

Insured's Birthdate: ____ /____ /____

Insured's Social Security # _____

Insurance Company: _____

Group No.: _____ Local No.: _____

Insurance Co. Address _____

Phone #: (____) _____

Insured's Employer: _____

Phone #: (____) _____

Do you have dual coverage? ❒ Yes ❒ No If yes:

Insured's Name: _____

Relationship: _____

Insured's Birthdate: ____ /____ /____

Insured's Social Security # _____

Insurance Company: _____

Group No.: _____ Local No.: _____

Insurance Co. Address _____

Phone #: (____) _____

Insured's Employer: _____

Phone #: (____) _____

3 EMERGENCY INFORMATION

Name of relative or friend not living with you: _____ Relationship: _____

Complete Address: _____

Work #: (____) _____ Home #: (____) _____

4 HEALTH INFORMATION

Family Physician: _____

Phone #: (____) _____

Your current physical health is: ❒ Good ❒ Fair ❒ Poor

Are you currently under the care of a physician? ❒ Yes ❒ No

Please explain: _____

Do you smoke or have in the past smoked or used tobacco in any other form? ❒ Yes ❒ No How long? _____

Do you have any metal rods, pins or implants? ❒ Yes ❒ No

Are you taking any prescription/over-the-counter drugs? ❒ Yes ❒ No

Please list each one: _____

_____

_____

For women: Are you taking birth control pills? ❒ Yes ❒ No

HRT? ❒ Yes ❒ No

Are you pregnant? ❒ Yes ❒ No Week #: _____

Are you nursing? ❒ Yes ❒ No

5 PATIENT INFORMATION

Have you ever had any of the following diseases or medical problems? ***Please check those that apply:***

- ❒ Alcohol/Drug Abuse
- ❒ Allergies/Hay Fever/Hives
- ❒ Anemia
- ❒ Angina Pectoris
- ❒ Arthritis
- ❒ Artificial Joints/Bones/Valves
- ❒ Asthma
- ❒ Bleeding Problems
- ❒ Blood Disease
- ❒ Blood Transfusion
- ❒ Bruise Easily
- ❒ Cancer
- ❒ Congenital Heart Lesions
- ❒ Cortisone Medicine
- ❒ Cosmetic Surgery
- ❒ Diabetes
- ❒ Dizziness/Fainting
- ❒ Emphysema
- ❒ Epilepsy or Seizures
- ❒ Excessive Bleeding
- ❒ Fever Blisters
- ❒ Glaucoma
- ❒ Head Injuries
- ❒ Heart Disease
- ❒ Heart Murmur
- ❒ Heart Pacemaker
- ❒ Heart Surgery
- ❒ Hemophilia
- ❒ Hepatitis A or B
- ❒ High/Low Blood Pressure
- ❒ HIV Positive
- ❒ Jaundice
- ❒ Kidney Disease
- ❒ Liver Disease
- ❒ Mental Disorders
- ❒ Migraines
- ❒ Nervousness
- ❒ Pacemaker
- ❒ Psychiatric Treatment
- ❒ Radiation Treatment/ Chemotherapy/ Cobalt/ X-ray
- ❒ Respiratory Problems
- ❒ Rheumatic Fever
- ❒ Rheumatism
- ❒ Scarlet Fever
- ❒ Sickle Cell Disease
- ❒ Sinus Problems
- ❒ Stomach Problems
- ❒ Stroke
- ❒ Thyroid Disease
- ❒ Tuberculosis (TB)
- ❒ Ulcers
- ❒ Venereal Disease (Syphilis, Gonorrhea, etc.)
- ❒ Other _____

Please list any serious medical condition(s) that you have ever had: _____

Are you allergic to any of the following?

- ❒ Yes ❒ No Aspirin
- ❒ Yes ❒ No Codeine
- ❒ Yes ❒ No Darvon
- ❒ Yes ❒ No (local) Dental Anesthetics
- ❒ Yes ❒ No Erythromycin
- ❒ Yes ❒ No Jewelry/Metals
- ❒ Yes ❒ No Latex
- ❒ Yes ❒ No Nitrous Oxide
- ❒ Yes ❒ No Penicillin
- ❒ Yes ❒ No Percodan
- ❒ Yes ❒ No Sulfa
- ❒ Yes ❒ No Tetracycline
- ❒ Yes ❒ No Valium
- ❒ Yes ❒ No Other _____

6 DENTAL HISTORY

Why have you come to the dentist today? _____

How long since you have seen a dentist? _____

Are you currently in pain? ❒ Yes ❒ No

Do you require antibiotics before dental treatment? ❒ Yes ❒ No

Your current dental health is? ❒ Good ❒ Fair ❒ Poor

Have you ever had a serious/difficult problem associated with any previous dental work? ❒ Yes ❒ No

If so, please explain: _____

Do you floss daily? ❒ Yes ❒ No

Brush daily? ❒ Yes ❒ No

Type of bristles on your toothbrush? ❒ Hard ❒ Medium ❒ Soft

Have you ever had periodontal gum treatment? ❒ Yes ❒ No

Do your gums ever bleed? ❒ Yes ❒ No

Tender/Irritated? ❒ Yes ❒ No Ever itch? ❒ Yes ❒ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD?) ❒ Yes ❒ No

Are your teeth sensitive to heat, cold, sweets, pressure, or anything else?

Do you have loose, tipped or shifting teeth? ❒ Yes ❒ No

Do you have mobility in your teeth? ❒ Yes ❒ No

Do you still have wisdom teeth? ❒ Yes ❒ No

Do you have grinding or clenching? ❒ Yes ❒ No

Do you get headaches, earaches or neck pain? ❒ Yes ❒ No

Would you like fresher breath? ❒ Yes ❒ No

Would you like whiter teeth? ❒ Yes ❒ No

Are you happy with the way your smile looks? ❒ Yes ❒ No

If not, what would you change? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

_____ **Date** _____

Signature of patient, parent or guardian

Welcome to the practice of: J. Bayard DuBois, DDS PS

We are committed to providing you with optimum dental care and excellence in customer service. To achieve these goals, we greatly depend on your understanding of our appointment and payment policies. Thank you for choosing us and for taking time to carefully review the following.

Appointments

Your appointment time is reserved especially for you. We respect your busy schedule and make every effort to see you on time. Please help us achieve this goal by being punctual for your visit. A minimum of 24 hours notice is required if you are unable to keep your appointment. A broken appointment may result in a $50.00 charge. Thank you in advance for your cooperation. _____ (initial)

Financial Policy

Uninsured Patients: If you are not insured, full payment for services rendered is expected at the time of appointment. We accept cash, checks, Visa, and Master Card. We can help you make financial arrangements through Care Credit. We apply a $25.00 charge for all returned checks. _____ (initial)

Insured Patients: If you are insured, as a courtesy to you, we will gladly submit your insurance claims on your behalf. However, we expect and appreciate payment of any deductible along with estimated charges not covered by your insurance at the time services are rendered. We accept cash, checks, Visa, and Master Card. We can help you make financial arrangements through Care Credit. We apply a $25.00 charge for all returned checks. If for any reason your insurance does not pay, please be advised that you are responsible for any unpaid balance. _____ (initial)

Authorization and Release

The patient/guardian who is signing this form is responsible for all account transactions and balances. Outstanding balances over 60 days will accrue interest at the rate of 12%.

If insurance is involved: I authorize payment directly to J. Bayard DuBois, DDS of group benefits otherwise payable to me.

I understand and accept all of the above appointment & financial polices.

Patients Name:_____

Patient/Guardian Signature:_____

Date:_____

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

J. Bayard DuBois D.D.S.
121 N. Kennebeck Ave.
Kent, Wa. 98030
(253) 854-6300

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in the treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above the obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name:______________________________ Date:________________
Signature:________________________________
Relationship to Patient:____________________

Dependent family member also covered by this acknowledgement:

____

____

- -

For Office Use Only:
Were we're unable to obtain the patient's written acknowledgement of our Privacy Practices due to the following reasons:

☐ The patient refused to sign
☐ Communication barriers
☐ Emergency situation

Financial Policy - Insurance

For our patients with Dental Insurance:

As a courtesy to you, we will gladly submit your dental insurance claims for all treatment performed in our office. Please be aware that most insurance companies do not cover all treatment at 100%. This typically leaves our patients with an occasional balance or out-of-pocket expense. We expect and appreciate payment of any deductible and/or estimated fees not covered by your insurance at the time of service. Upon request, we will submit a Pre-Authorization to your insurance company, to determine their projected benefits. This may take 4-6 weeks to receive back from the company.

There are many different insurance carriers, each with several plans within their company. Each of these plans differs in their benefit coverage and policies. Our staff will assist you, as a courtesy, but ultimately **you are responsible** for knowing your own benefits (i.e.: yearly maximum, deductible, covered and non-covered procedures, waiting periods, etc).

If for any reason your insurance does not pay, please understand that you are fully responsible for the unpaid charges.

We accept cash, checks, Visa, and MasterCard. We can also help you make financial arrangements through CareCredit. We will apply a $25 charge for all returned checks.

Thank you!

Dr. J. Bayard DuBois

I understand the above policy.

Print Name _____

Signature _____

Date _____

J. Bayard DuBois, D.D.S., P.S.
Consent for Dental Procedure and Acknowledgement of Receipt of Information

State law requires us to obtain your consent to perform any contemplated dental treatment or oral surgery. Please read this form carefully and ask us about anything that you do not understand. We will be pleased to explain it.

I hereby authorize and direct J. Bayard DuBois, D.D.S., P.S., to perform upon myself and/or child (or legal ward for whom I am empowered to consent) the following dental or oral surgery procedures if needed. In general terms the dental treatment or procedures may include:

1. Examination of teeth, mouth and neck
2. Radiographs (x-rays) of the head, teeth and jaw
3. Cleaning of the teeth and application of fluoride
4. Use of local anesthesia to numb the teeth and tissues
6. Treatment of diseased or injured teeth with composite (plastic fillings/glass ionomer, which may or may not contain fluoride) and crowns (porcelain, gold or a combination thereof)
7. Extraction of diseased teeth (including front teeth)
8. Replacement of extracted or missing teeth with dental prosthesis to maintain the space or preserve the esthetics of the smile.
9. Treatment of malposed (crooked) teeth
10. Use of nitrous oxide to control apprehension
11. Other_____

Dr. DuBois has explained the nature and purpose of treatment and procedures to me in general terms. Alternate procedures or methods of treatment, if any, have also been explained to me, as have their advantages, disadvantages, the risks, consequences and probable effectiveness of each, as well as the prognosis if no treatment is provided. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee, expressed or implied either as to the result of the treatment or as to cure. I further authorize Dr. DuBois to perform any of the described dental services that in his judgment are advisable for myself, child, and/or legal ward with exception of (if none, so state):_____

I authorize Dr. DuBois to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research and scientific publications.

The most common complications associated with pediatric dental treatment include nausea following the administration of topical fluoride and children biting and injuring their tongue or lip following the administration of local anesthesia. Rare complications include vomiting, prolonged bleeding, infection, swelling, swallowing or aspiration of a crown or an extracted tooth, injury to the tongue and/or lips, damage to and possible loss of existing teeth and/or restorations (fillings), allergic reactions, injury to nerves near the treatment site, prolonged or permanent numbness, and fracture of a tooth root which may require additional surgery for its removal. For patients with heart disease, the risk of sub acute bacterial endocarditis (heart infection) following dental treatment exists. Therefore, antibiotics will be prescribed to minimize the risk. I further understand and accept that complications may require additional medical, dental, or surgical treatment and may require hospitalization.

I hereby state that I have read and understand the consent form, that I have been given the opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered to questions, which may arise during the course of my child's treatment. I further understand that I am free to withdraw my consent to treatment at any time, and that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name_____Date_____

Signature of parent or legal guardian _____Relationship to Patient_____

I certify that I explained the above procedures to the parent or legal guardian before requesting their signature.
_____Date_____