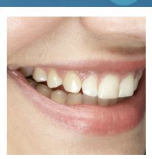
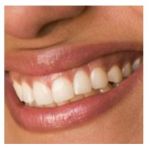
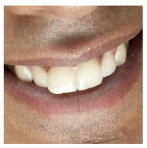
Ranieu Family Dental
512 NE 81st St
Ste # G
Vancouver, WA 98665
(360)735-9422
ranieufamilydental@gmail.com
ranieudental@gmail.com

Patient Name: Last | First | MI | Preferred Name

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Medical Care Physician's name & phone number; Date last seen:

Please mark any of the following to indicate Yes in response to the question:

- ☐ Have you ever had complications following dental treatment?
- ☐ Are you currently under the care of a physician due to a specific condition?
- ☐ Have you been hospitalized within the last 5 years due to a surgery or illness?
- ☐ Are you currently taking any prescription or non-prescription medications?
- ☐ Do you use tobacco (smoking or chewing)?
- ☐ Do you take Bisphosphonates: Actonel, Actonel+Ca, Aredia, Boniva, Didronel, Fosamax, Fosamax+D, Reclast, Skelid, and Zometa?
- ☐ Do you have any other conditions, diseases, etc., not listed above that we should be aware of?

If any of the previous questions are marked, please explain:

## Medical & Dental History Form

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date?

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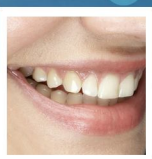
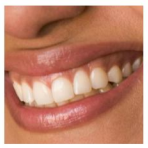
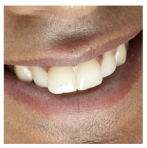

Please indicate if you have experienced any of the following:

- [ ] *Pre-Med - Amox
- [ ] *Pre-Med - Clind
- [ ] *Pre-Med - Other
- [ ] Allergies
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Erythro
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Arthritis
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Blood Disease
- [ ] Cancer
- [ ] Diabetes
- [ ] Dizziness
- [ ] Epilepsy
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Glaucoma
- [ ] Head Injuries
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] HIV
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] Mental Disorders
- [ ] Nervous Disorders
- [ ] Other
- [ ] Pacemaker
- [ ] Pregnancy
- [ ] Radiation Treatment
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Russian Speaking
- [ ] Sinus Problems
- [ ] Spanish Speaking
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Venereal Disease

Do you have any other health issues or allergies?

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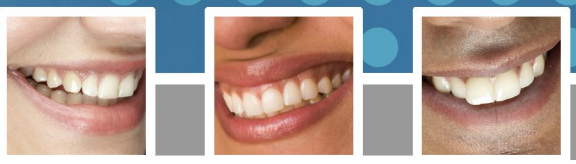

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

How frequently do you brush your teeth?

○ 3 (+) a day ○ Twice a day ○ Once a day ○ Weekly ○ Seldom

How frequently do you floss your teeth?

○ 1 (+) a day ○ 2 - 6 weekly ○ 1 - 6 monthly ○ Seldom ○ Never

Please mark any of the following to indicate Yes in response to the question:

☐ Do your gums bleed when you brush or floss?
☐ Do your teeth experience sensitivity to cold or hot temperatures?
☐ Are any of your teeth currently causing you pain?
☐ Do you grind your teeth (either consciously or during sleep)?
☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
☐ Do you currently have any dental implants, dentures, or partials?
☐ Are you happy with your smile?
☐ Are you interested in whitening your teeth?
☐ Do you want to straighten your teeth?

If any of the previous questions are marked, please explain:

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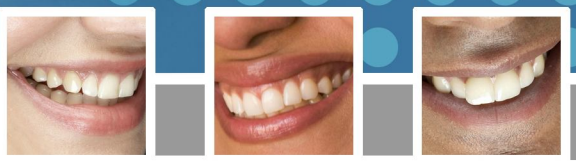

☐ To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next detal appointment without fail.

## Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient (Please Print):

_____

Response Date: _____

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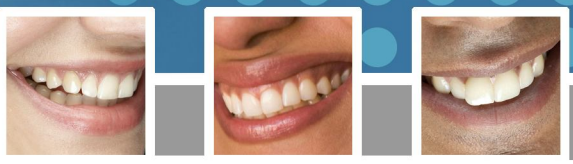

# Patient Information

Chart #. _____
FOR OFFICE USE ONLY

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Prev. Visit: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____ _____

_____ (City) _____ (State) _____ (Zip Code)

Who can we thank for referring you to our office?

_____

What is your preferred language?

_____

Do you have dental insurance?

◯ Yes ◯ No

Insurance Company Name and Employer Name or HR contact:

_____

Medical Insurance Name and ID#:

_____

Parent or guardian name (print) if patient is under 18 years old:

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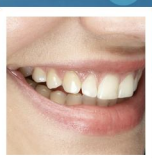
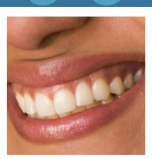
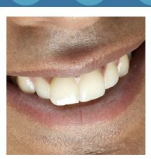

## Financial and Insurance Policies

We are committed to providing you the highest quality dental care, and keeping you up-to-date so you can fully participate in your dental care, is an important part of this. Our financial policy is intended to serve you by minimizing unexpected costs. So, if you carry dental insurance, please bring your insurance card with you to your first appointment. The following sections contains information regarding our Financial Policies. Please, check each box to the left to indicate you have read and understand them.

☐ Your dental benefits are based on a contract between your employer and insurance company. As an extra service, we will contact the insurance company to obtain a breakdown of your benefits, but it is not a guarantee of coverage. If you have questions regarding your dental benefits please contact your employer or insurance directly. Most dental benefit plans will not pay for all of your dental care, as it is only meant to assist you.

☐ We currently accept all private care insurance plans. Although we can maintain computerized histories of payments by a given company, they do change; therefore it is impossible to give you a guaranteed quote. We ESTIMATE your portion based on the most up to date information we have, but it is only an estimate. Keep in mind this is not a guarantee of coverage.

☐ Your estimated patient responsibility for treatment is due at the time of service, and we will bill your insurance for the remainder as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full from you. You can then collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between you and your insurance company. Ultimately, you are responsible for all charges incurred in our office.

☐ Dental services are to be paid before each appointment with cash, Visa, MasterCard or dental financing. We DO NOT accept checks. As a courtesy, we will bill your insurance directly for services received. Estimated co-payments and deductibles not covered by your insurance carrier are due at the time of service.

☐ We offer credit program through third party agencies CareCredit, Chase Health Advance, and Citi Health. These companies offer low, and in some cases, zero-interest health credit, which provide a flexible payment plan and can also be used for various other health services, on approved credit. Information is available at our front desk.

☐ I have read the information above regarding the Payment Policy for the dental practice, and agree to adhere to the guidelines.

Signature of patient, parent, or guardian:

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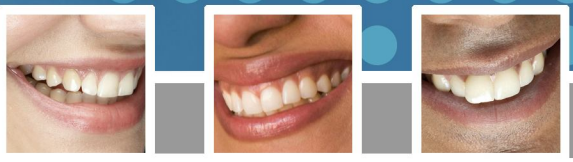

Signature: _____

Date: _____

Response Date: _____

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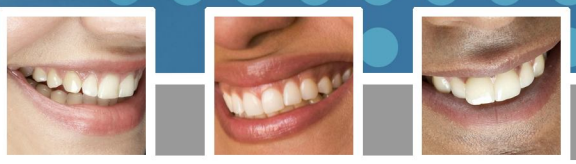

# Ranieu Privacy Practices & Achnowledgement of Records Request

Patient Name: _____ _____ ___ _____
Last First MI Preferred Name

I understand that State and Federal laws, as well as ethical and licensure requirements impose obligations with respect to patient confidentiality that limit the ability to make use of certain services or to transmit certain information to third parties. I understand the dental practice will represent and warrant that they will, at all times during the terms of this Agreement and thereafter, comply with all laws directly or indirectly applicable that may now or hereafter govern the gathering, use, transmission, processing, receipt, reporting, disclosure, maintenance, and storage of my information, and use their best efforts to cause all persons or entities under their direction or control to comply with such laws. I understand the dental practice will use commercially reasonable efforts to maintain the confidentiality of all patient information. I understand the dental practice CANNOT AND DOES NOT ASSUME ANY RESPONSIBILITY FOR MY USE OR MISUSE OF PATIENT INFORMATION OR OTHER INFORMATION TRANSMITTED AS A REQUEST OF RECORDS. ALL RECORD REQUEST REQUIRE PRIOR WRITEN AUTHORIZATION BY THE PATIENT OR LEGAL GUARDIAN.

☐ I have read and received a copy of this office's Notice of Privacy Practices and have read the information above regarding My Records.

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

_____

Response Date: _____