Jonny Fisher DDS

Excellence in Dentistry

PATIENT INFORMATION

Name:_____Date:_____
Last First (Preferred Name)

☐Male ☐ Female ☐ Married ☐Single ☐ Child

Social Security #:_____ Birth Date:___/___ /___

☐Phone (Home):_____ ☐ (Work):_____ ☐(Cell):_____

(mark best contact)

Email:_____ How do you prefer reminders? Email Text Phone

Home/Mailing Address:_____
Street City, State Zip Code

RESPONSIBLE PARTY (under age 18 or someone else making payments)

The following is for: ☐patient's spouse ☐patient's parent ☐other:_____

Name:_____Date:_____
Last First (Preferred Name/Nickname)

☐Male ☐Female ☐Married ☐Single ☐ Other_____

Social Security #:_____ Driver's License #:_____ Birth Date:___/___ /___

☐Phone (Home):_____ ☐ (Work):_____ ☐(Cell):_____

(mark best contact)

Mailing Address:_____
Street City,State Zip Code

EMERGENCY CONTACT

First Name:_____Last Name:_____ Phone:_____

Relationship:_____

DENTAL INSURANCE

Name of Subscriber: _____ Subscriber's Birth Date:___/___ /___
Last First MI

Social Security#:_____ Plan ID #:_____ Group #:_____

Subscriber's Employer Name:_____

Insurance Plan:_____

Do you have additional insurance? If so, please complete the following section:

Name of Subscriber: _____ Subscriber's Birth Date:___/___ /___
Last First MI

Social Security#:_____ Plan ID #:_____ Group #:_____

Subscriber's Employer Name:_____

Insurance Plan:_____

HEALTH HISTORY

Patient Name:_____Birth Date:_____Phone:_____
How can we help you today?_____
How did you hear about us?_____

Yes No Are you in pain now? If so, please note severity (10-most extreme) 0 1 2 3 4 5 6 7 8 9 10
Yes No Has there been a change in your health within the last three years? If yes, please describe._____
Yes No Are you currently being treated by a physician? If so, for what?
*Facility:_____Physician Name:_____Phone:_____
Yes No Have you had problems with prior dental treatment? If yes, please explain.

PLEASE <u>CIRCLE</u> ANY YOU HAVE OR EVER HAD:

Heart disease Heart attack Heart defects
High blood pressure Stroke Prolonged bleeding
Diabetes Hepatitis Cancer HIV
Asthma Emphysema TB Other lung disease
Radiation treatments Chemotherapy
Artificial joints Prosthetic heart valve
***Allergies to any**:* foods medications latex metals

CURRENT MEDICATIONS & INDICATIONS:

1._____ **5.**_____
2._____ **6.**_____
3._____ **7.**_____
4._____ **8.**_____

Preferred Pharmacy:_____Location:_____Phone:_____

HAVE YOU EVER OR ARE YOU CURRENTLY TAKING:

Yes No Medications, over-the-counter medicines (including Aspirin), or natural remedies? (Please list above)
Yes No Alcohol? If yes, how often? Day/week
Yes No Tobacco? If yes, how often? Day/week
Yes No Recreational Drugs? If yes, how often? Day/week
Yes No Antibiotics/premedication for dental appointments?
Yes No "Bisphosphonates' ' for bone strengthening or osteoporosis (Fosamax, Boniva, Actonel, etc.)

WOMEN:

Yes No Are you or could you be pregnant or nursing?
Yes No Are you taking birth control pills?

To the best of my knowledge, I have answered all questions completely & accurately. I will inform my dentist of any change in my health and/or medications. **I understand that I am financially responsible for <u>all charges, whether or not paid by insurance</u> & that Payments are <u>due in full at the time of treatment</u>** (unless prior arrangements have been made).

Patient's signature:_____Date:_____

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Payment Policy

- Payment is due at the time of treatment. 🙏
- We accept cash, checks, and major credit cards.
- In-House payment plans are available allowing you to start treatment today and pay over time (a 1.5% monthly interest fee applies).
- If you have current coverage through a dental plan, they may help offset the cost of treatment. As a courtesy, we generally bill your dental plan provider on your behalf.
- It is your responsibility for the full amount of treatment rendered, regardless of the anticipated benefits of your dental plan.
- If a payment is past due on your account and left unpaid or misses an agreed paid by date then you may accrue a $50 late fee.
- Appointments that extend beyond 2 hours will require a payment 50% of the estimated out of pocket amount to reserved time in our schedule. The amount paid would be applied to the appointment unless a short notice cancellation within 24 hours happens, then the amount would be applied to a cancellation fee.

Cancellation Policy

- When you schedule an appointment, that time is set aside specifically for you. 😀
- Please give us **48 hour notice** when needing to cancel or reschedule an appointment.
- Appointments canceled or missed within less than 24 hours are subject to a **$95 fee** assessed to your account. As a courtesy, we generally waive the first infraction. (We know life and snow happens).
- We are unable to accept cancellations outside of normal office hours.
- Cancellation fees must be paid prior to scheduling another appointment.

Seriously... what's the big deal? Short notice cancellations can cause these significant issues:

- Being unable to receive the your dental treatment in a timely manner.☹️ (Your Dr may be booked out a month or more.)
- The doctor and team are prepared with equipment & materials specific to your appointment.
- Another community member could have been scheduled in that valuable time slot and received necessary (sometimes urgent) dental treatment.

HIPAA & Notice of Privacy Practices

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding my protected health information. We maintain a *Notice of Privacy Practices* at our office with a complete description of the uses & disclosures of your health information. This document is available upon request.

Printed Name: _____ **Relationship to Patient:** _____

Signature: _____ **Date:** _____

650 SE Bishop Blvd, Ste 200
Pullman, WA 99163
(509) 332-2366

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Authorization to Release Dental Records

I hereby request & authorize_____to

(name of dentist/office)

release any and all dental records including x-rays, SRP dates, restorations within 2-3 years, or crowns in past 7 years for the
following patients:

Name_____DOB_____
Name_____DOB_____
Name_____DOB_____
Name_____DOB_____
Name_____DOB_____

Please send (preferably by email) to:

Jonny Fisher DDS
650 SE Bishop Blvd, Ste. 200
Pullman, WA 99163
(509) 332-2366
Info@jonnyfisherdds.com

Name: _____

Signature: _____

Relationship to Patient: Self Parent Spouse Other:_____