Welcome to

Pacific Ave Dental

Allan L. Hablutzel, D.D.S. Family Dentistry

820 Pacific Ave., Suite 204, Bremerton, WA 98337

Patient Information

Welcome to our office! We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, please don't hesitate to ask.

Patient name____ Today's date__________________

Date of Birth ___________________________SSN_____________________ Gender__________________

Driver's license number__________________________________ State___________________________

Home address____

Phone____________________ Cell Phone____________________ Email __________________________

Preferred method of communication? _______________________________________

Billing address *(if different from above)* ____

Employer/occupation_______________________________________Business phone__________________

Spouse's name____Spouse's phone__________________

Emergency contact and phone *(other than spouse)* ____

Primary dental insurance_______________________________________ Group number______________

Subscriber's name____Date of birth_______________

Subscriber's insurance number_____________________________ Age__________ Sex___________

Secondary dental insurance____________________________________Group number__________________

Secondary subscriber's name __________________________________ Date of birth__________________

Subscriber's insurance number_____________________________ Age__________ Sex___________

Name of your medical doctor_____________________________ Date of last visit _____________________

Name of previous dentist_________________________________Date of last visit _____________________

Whom may we thank for referring you? ____

MEDICAL HISTORY

PATIENT NAME ______________________________________ **Birth Date** _________________________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ☐Yes ☐No

If yes, please explain: ____

Have you ever been hospitalized or had a major operation? ☐Yes ☐No

If yes, please explain: ____

Have you ever had a serious head or neck injury? ☐Yes ☐No

If yes, please explain: ____

Are you currently taking any medications, pills, or drugs? ☐Yes ☐No

If yes, please explain: ____

Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No

If yes please explain: ____

Are you taking or have you ever taken biophosphonates via IV administration (for osteoporosis)? ☐Yes ☐No

If yes please explain: ____

Are you on a special diet? ☐Yes ☐No

Do you use tobacco? ☐Yes ☐No

If yes please explain: ____

Do you use controlled substances? ☐Yes ☐No

If yes please explain: ____

Do you need to pre-medicate (take an antibiotic prior to dental treatment)? ☐Yes ☐No

If yes, please explain: ____

Are you allergic to any of the following?

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics ☐Other

If other, please explain: ____

Women Only: **Are you Pregnant/Trying to get pregnant? ☐Yes ☐No** **Currently Nursing? ☐Yes ☐No**
Taking oral contraceptives? ☐Yes ☐No

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 I or II?	☐Yes☐No	Hepatitis A	☐Yes☐No	Recent Weightloss	☐Yes☐No
Anaphylaxis	☐Yes☐No	Drug Addiction	☐Yes☐No	Hepatitis B or C	☐Yes☐No	Renal Dialysis	☐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	Hypo-glycemia	☐Yes☐No	Sickle Cell Disease	☐Yes☐No
Asthma	☐Yes☐No	Fainting/ Dizziness	☐Yes☐No	Irregular Heartbeat	☐Yes☐No	Sinus Trouble	☐Yes☐No
Blood Disease	☐Yes☐No	Frequent Cough	☐Yes☐No	Kidney Problems	☐Yes☐No	Spina Bifida	☐Yes☐No
Blood Transfusion	☐Yes☐No	Frequent Diarrhea	☐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	Mitral Valve Prolapse	☐Yes☐No	Tonsillitis	☐Yes☐No
Chest Pains	☐Yes☐No	Heart Attack/Failure	☐Yes☐No	Osteo-porosis	☐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 Pace Maker	☐Yes☐No	Parathyroid Disease	☐Yes☐No	Ulcers	☐Yes☐No
Convulsions	☐Yes☐No	Heart Disease	☐Yes☐No	Psychiatric Care	☐Yes☐No	Venereal Disease	☐Yes☐No
						Yellow Jaundice	☐Yes☐No

Have you ever had any serious illness not listed above? ☐**Yes** ☐**No**

If yes, please explain: ____

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Dental Health History:

Do you have or have you ever had the following?

Apprehension with dental treatment	☐Yes☐No	Clenching or Grinding	☐Yes☐No
Gag Easily	☐Yes☐No	Pain in jaw	☐Yes☐No
Wear Dentures	☐Yes☐No	Sensitive Teeth	☐Yes☐No
Food catches between teeth	☐Yes☐No	Gums that bleed/ are sore	☐Yes☐No

How often do you brush? ______________________________________ **Floss?**__________________________

Is there anything we can do or not do to make your dental visit more pleasurable?

____

Financial Policy:

Payment is expected at the time of service regardless of insurance coverage. For your convenience we accept VISA, Mastercard, Discover, American Express, Cash, Checks, and Care Credit. If you have insurance, we will do our best to estimate your insurance coverage with the information provided to us by your insurance company. The estimated portion is due at the time of service. Many insurance companies have additional stipulations and polices that may affect your coverage. It is your responsibility to know your insurance and coverage. Any balances unpaid by insurance is the patient's responsibility to pay. As a courtesy, we will bill your dental insurance on your behalf. By signing below you are authorizing our office to bill your insurance on your behalf.

Cancellation/ Failed Appointment Policy:

We have reserved time in our schedule just for you, and we have not offered that time to any other patient. Out of respect for the time of our patients we reserve the right to charge a fee of $50 per hour for appointments failed or cancelled without 48 business hours' notice. Kindly give us 2 business days' notice if you need to change an appointment.

Receipt of Privacy Practices:

I, the undersigned, have received the Notice of Privacy Practices as presented to me by Pacific Ave Dental/ Dr. Allan Hablutzel, DDS. I have read the Notice and any questions have been answered. I understand that I have certain rights and responsibilities under the HIPAA rulings, and that I agree to the terms provided in the Notice of Privacy Practices, including any opt-outs.

I know that I have the right to receive a written copy of the Notice of Privacy Practices at any time and that it is available either in our office or electronically by requesting it from the Privacy Officer in our office.

I have read, understand, and accept the terms of the above outlined policies for financial commitments that I (or the below named patient) may incur as a result of treatment at this office.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Patient/ Parent Signature ____ Date __________________________

Doctor signature ____Date __________________________