

# WELCOME

**ALBERT R. BIRD, D.D.S, P.S.**  
**ZACHARY A. BIRD, D.M.D.**  
FAMILY DENTISTRY

## Patient Information

Date \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Patient's Name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

If patient is a minor, give parent's or guardian's name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

## Responsible Party Information

Name \_\_\_\_\_  
Last First Middle Marital Status

Mailing Address \_\_\_\_\_  
Street City State Zip

How long at this address? \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Previous Address (if less than 3 yrs.) \_\_\_\_\_  
Street City State Zip

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

Spouse's Name \_\_\_\_\_  
Last First MI Relationship to Patient \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. Years Employed \_\_\_\_\_

Employer's Address \_\_\_\_\_  
Street City State Zip

## Insurance Information

Insured's Name \_\_\_\_\_ Insured's ID or SSN \_\_\_\_\_

Ins. Company Name \_\_\_\_\_

Ins. Company Address \_\_\_\_\_

Ins. Company Phone # (\_\_\_\_\_) \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

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

Insured's Name \_\_\_\_\_ Insured's Soc. Sec. # \_\_\_\_\_

Ins. Company Name \_\_\_\_\_ Insured's Employer \_\_\_\_\_

Ins. Company Address \_\_\_\_\_

Ins. Company Phone # (\_\_\_\_\_) \_\_\_\_\_ Group No. \_\_\_\_\_ Union Local No. \_\_\_\_\_

## Emergency Information

Name of nearest relative not living with you \_\_\_\_\_

Relationship \_\_\_\_\_ Phone \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ and assign directly to Dr. \_\_\_\_\_ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Date \_\_\_\_\_

Please print name of Patient, Parent, Guardian or Personal Representative \_\_\_\_\_

Relationship to Patient \_\_\_\_\_





**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 in 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, don't hesitate to ask.**

Patient Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_

Name and phone # of your medical doctor: \_\_\_\_\_

Date of last visit to medical doctor: \_\_\_\_\_ Name of previous dentist: \_\_\_\_\_

Date of last visit to dentist: \_\_\_\_\_ Last cleaning: \_\_\_\_\_

Referred to us by: \_\_\_\_\_

**DENTAL HEALTH HISTORY**

**Please mark any that apply:**

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| Are you apprehensive about dental treatment? _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had problems with previous dental treatment _____             | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you gag easily? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you wear dentures? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does food catch between your teeth? _____                              | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have difficulty chewing your food? _____                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you chew on only one side of your mouth? _____                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you avoid brushing any part of your mouth because of pain? _____    | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed easily? _____                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums bleed when you floss? _____                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your gums feel swollen or tender? _____                             | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever noticed slow-healing sores in or about your mouth? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Are your teeth sensitive? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you feel twinges of pain when your teeth come in contact with:      |                          |                          |
| Hot foods or liquids? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold foods or liquids? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sours? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Sweets? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take fluoride supplements? _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you prefer to save your teeth? _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you dissatisfied with the appearance of your teeth? _____          | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you want complete dental care? _____                                | <input type="checkbox"/> | <input type="checkbox"/> |
| How often do you brush? _____  |                          |                          |
| How often do you floss? _____  |                          |                          |
| Does your jaw make noises so that it bothers you or others? _____      | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you clench or grind your jaws frequently? _____                     | <input type="checkbox"/> | <input type="checkbox"/> |
| Do your jaws ever feel tired? _____                                    | <input type="checkbox"/> | <input type="checkbox"/> |

**Please mark any that apply:**

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Does your jaw get stuck so that you can't open freely? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does it hurt when you chew or open wide to take a bite? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you unable to open your mouth as far as you want? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have earaches or pain in front of the ears? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have any jaw symptoms or headaches upon awaking in the morning? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you take medications, or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a temporomandibular (jaw) disorder (TMD, TMJ)? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you aware of an uncomfortable bite? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you had a blow to the jaw (trauma)? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you a habitual gum chewer or pipe smoker? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble falling asleep or staying asleep? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you sleep well? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you snore? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you stop breathing in your sleep? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Are you sleepy during the daytime? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Have you ever had:  |                          |                          |
| Orthodontic treatment? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| Oral surgery? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| Periodontal treatment? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| A mouth guard or bite plate? _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| A serious injury to the mouth or head?<br>Please describe: _____  |                          |                          |
| _____   |                          |                          |

History Review	BP Taken: _____	Date: _____
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# MEDICAL HEALTH HISTORY

## Do you have, or have you had any of the following?

	Yes	No
Heart Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood Problems _____		
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleeds _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>
Methemoglobinemia (Blue baby disease) _____	<input type="checkbox"/>	<input type="checkbox"/>
Allergy Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Skin rashes _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>
Intestinal Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special Diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>
G.E.R.D. _____	<input type="checkbox"/>	<input type="checkbox"/>
Bone or Joint Problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement _____ (e.g., total hip, pins, or implants)	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>
Premedications required by physician _____	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much _____	<input type="checkbox"/>	<input type="checkbox"/>

Date: \_\_\_\_\_

Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive/AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about?		
If so, please describe: _____		
_____		

## Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine") _____	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Barbituates, sedatives, or sleeping pills _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen _____	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics _____	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals _____	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam _____	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>

## During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs _____	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin) _____	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine _____	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers _____	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug _____	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin _____	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin _____	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids) _____	<input type="checkbox"/>	<input type="checkbox"/>
Natural Remedies _____	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements _____	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis medication (e.g. Fosamax) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other:		
List name and dosage _____		
_____		
_____		
_____		

## Women

	Yes	No
Are you taking contraceptives or other hormones? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date _____		
Are you nursing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms? _____	<input type="checkbox"/>	<input type="checkbox"/>
_____		
_____		

Patient/Parent Signature: \_\_\_\_\_

Dentist Initial: \_\_\_\_\_

# Bird Family Dentistry

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Albert R. Bird, D.D.S., P.S.

Zachary A. Bird, D.M.D.

## Our Policy of Care and Payment

Ensuring that our patients receive high quality care is the goal of our practice.

**Appointment Policy:** Having a full and productive schedule helps us to maintain our standard of top quality dental care and to keep our fees reasonable for our patients. The charge for a “no show” or appointment cancelled with less than 24 hours notice is \$50 and must be paid before your next appointment will be scheduled.

**Payment Options:** Payment for dental treatment is due at the time of treatment. We do not offer any “in office” payment plans.

Cash or Check: We offer a 5% discount for payment in full at the time of treatment.

Major Credit Cards: We are happy to accept payment by MasterCard, Visa, Discover or American Express

Care Credit: This is an “out of office” financing option for payment plans. (Subject to credit approval.)

Health Savings Account/Flex Plans: We can help you utilize these funds.

**Dental Insurance:** We will file the necessary forms to see that you receive the full benefits of your coverage; however we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and your insurance company, we expect all patients to be responsible directly for all charges. If for some reason your insurance has not paid their portion within 60 days from the date of service, you are responsible for payment at that time. The portion of treatment that is covered by dental insurance is payable at the time of treatment.

**Past Due Accounts:** Occasionally, accounts become delinquent. We assign past due accounts to our collection service. This can be avoided by keeping in contact with us; we do not want this action any more than you do. Unpaid balances will be subject to a late fee service charge of 1.5% per month, at 18% APR, after 60 days.

Please feel free to contact us if you ever have concerns about your dental health or account status. Please sign below indicating you have read and understand our office policies.

I have read and agree to this Office Policy.

\_\_\_\_\_  
**Signature of Patient/Responsible Party**

\_\_\_\_\_  
**Date**

4707 S. Junett Street, Suite A Tacoma, WA 98409

(253) 475-8934 [www.drbird.com](http://www.drbird.com) Fax: (253) 472-0402

# Bird Family Dentistry

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Albert R. Bird, D.D.S., P.S.

Zachary A. Bird, D.M.D.

## HIPPA PRIVACY POLICY

## PATIENT CONSENT FORM

## NOTICE OF PRIVACY PRACTICES-

### ACKNOWLEDGEMENT

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We keep a record of health care services we provide you. You may ask to see a copy of that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office staff.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

*By my signature below I acknowledge receipt of the Notice of Privacy Practices*

\_\_\_\_\_  
Patient of legally authorized individual signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name if signed on behalf of the patient

\_\_\_\_\_  
Date

This form will be retained in your records

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