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 _____ Relationship to Patient _____
Last First MI

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 currant 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

DATE	RECALL HEALTH HISTORY UPDATE

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

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 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?	❒	❒
Have you had problems with previous dental treatment	❒	❒
Do you gag easily?	❒	❒
Do you wear dentures?	❒	❒
Does food catch between your teeth?	❒	❒
Do you have difficulty chewing your food?	❒	❒
Do you chew on only one side of your mouth?	❒	❒
Do you avoid brushing any part of your mouth because of pain?	❒	❒
Do your gums bleed easily?	❒	❒
Do your gums bleed when you floss?	❒	❒
Do your gums feel swollen or tender?	❒	❒
Have you ever noticed slow-healing sores in or about your mouth?	❒	❒
Are your teeth sensitive?	❒	❒
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	❒	❒
Cold foods or liquids?	❒	❒
Sours?	❒	❒
Sweets?	❒	❒
Do you take fluoride supplements?	❒	❒
Do you prefer to save your teeth?	❒	❒
Are you dissatisfied with the appearance of your teeth?	❒	❒
Do you want complete dental care?	❒	❒
How often do you brush?		
How often do you floss?		
Does your jaw make noises so that it bothers you	❒	❒
or others?	❒	❒
Do you clench or grind your jaws frequently?	❒	❒
Do your jaws ever feel tired?	❒	❒

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

History Review BP Taken: Date:

MEDICAL HEALTH HISTORY

Do you have, or have you had any of the following? **Yes** **No**

Heart Problems ☐ ☐
- Chest Pain ☐ ☐
- Shortness of breath ☐ ☐
- Blood pressure problem ☐ ☐
- Heart murmur ☐ ☐
- Heart valve problem ☐ ☐
- Taking heart medication ☐ ☐
- Rheumatic fever ☐ ☐
- Pacemaker ☐ ☐
- Artificial heart valve ☐ ☐

Blood Problems
- Easy bruising ☐ ☐
- Frequent nosebleeds ☐ ☐
- Abnormal bleeding ☐ ☐
- Blood disease (anemia) ☐ ☐
- Ever require a blood transfusion? ☐ ☐
- Methemoglobanemia (Blue baby disease) ☐ ☐

Allergy Problems ☐ ☐
- Hay fever ☐ ☐
- Sinus problems ☐ ☐
- Skin rashes ☐ ☐
- Taking allergy medication ☐ ☐
- Asthma ☐ ☐

Intestinal Problems ☐ ☐
- Ulcers ☐ ☐
- Weigh gain or loss ☐ ☐
- Special Diet ☐ ☐
- Constipation/Diarrhea ☐ ☐
- Kidney or bladder problems ☐ ☐
- G.E.R.D. ☐ ☐

Bone or Joint Problems ☐ ☐
- Arthritis ☐ ☐
- Back or neck pain ☐ ☐
- Joint replacement ☐ ☐
  - (e.g., total hip, pins, or implants) ☐ ☐

Fainting Spells, Seizures, or Epilepsy ☐ ☐
Stroke(s) ☐ ☐
Frequent or severe headaches ☐ ☐
Thyroid problems ☐ ☐
Persistent cough or swollen glands ☐ ☐
Premedications required by physician ☐ ☐
Cancer/Tumor ☐ ☐

Diabetes ☐ ☐
- Urinate more than 6 times a day ☐ ☐
- Thirsty or mouth is dry much of the time ☐ ☐
- Family history of diabetes ☐ ☐

Tuberculosis or other respiratory disease ☐ ☐

Do you drink alcohol ☐ ☐
- If so, how much ☐ ☐

Do you smoke? ☐ ☐
- If so, how much ☐ ☐

Date: _____

Hepatitis, jaundice, or liver trouble ☐ ☐
Herpes or other STD ☐ ☐
HIV-positive/AIDS ☐ ☐
Glaucoma ☐ ☐
Do you wear contact lenses ☐ ☐
History of head injury? ☐ ☐
Epilepsy or other neurological disease? ☐ ☐
History of alcohol or drug abuse? ☐ ☐
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") ☐ ☐
Penicillin or other antibiotics ☐ ☐
Sulfa drugs ☐ ☐
Barbituates, sedatives, or sleeping pills ☐ ☐
Asprin, Acetaminophen, or Ibuprofen ☐ ☐
Codeine, Demerol, or other narcotics ☐ ☐
Reaction to metals ☐ ☐
Latex or rubber dam ☐ ☐
Other ☐ ☐

During the past 12 months, have you taken any of the following? **Yes** **No**

Antibiotics or sulfa drugs ☐ ☐
Anticoagulants (e.g., Coumadin) ☐ ☐
High blood pressure medicine ☐ ☐
Tranquilizers ☐ ☐
Insulin, Orinase, or similar drug ☐ ☐
Aspirin ☐ ☐
Digitalis or drugs for heart trouble ☐ ☐
Nitroglycerin ☐ ☐
Cortisone (steroids) ☐ ☐
Natural Remedies ☐ ☐
Nonprescription drug/supplements ☐ ☐
Osteoporosis medication (e.g. Fosamax) ☐ ☐
Other:
List name and dosage _____

Women **Yes** **No**

Are you taking contraceptives or other hormones? ☐ ☐
Are you pregnant? ☐ ☐
- If so, expected delivery date _____

Are you nursing? ☐ ☐
Have you reached menopause? ☐ ☐
- If so, do you have any symptoms? ☐ ☐

Patient/Parent Signature: _____

Dentist Initial: _____

Bird Family Dentistry

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 Fax: (253) 472-0402

Bird Family Dentistry

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

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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