triCity DENTAL CARE

DR. ANTONIO LOPEZ-IBARRA, DDS
FAMILY & COSMETIC DENTISTRY

A DENTAL EXPERIENCE LIKE NO OTHER!

www.tricitydentalcarewa.com
509.579.0759
3711 PLAZA WAY, STE 120.
KENNEWICK, WA 99338

WELCOME TO OUR OFFICE ~ WE LOOK FORWARD TO GETTING TO KNOW YOU

Date: ☐NEW PATIENT ☐UPDATE

Patient:

LAST FIRST MI PREFERRED TITLE

☐MALE ☐FEMALE ☐CHILD ☐STUDENT ☐SINGLE ☐MARRIED ☐DIVORCED ☐WIDOWED

Patient Date of Birth: Patient SSN:

Address:

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME:
CELL:
TEXT OK?:

E-Mail:

Referral? ☐Yes ☐ No Whom may we thank for referring you:

EMERGENCY CONTACT

NAME RELATIONSHIP Tel:

EMPLOYMENT INFORMATION

Employer: Occupation:

DENTAL HISTORY

Previous Dentist/clinic: Reason for change:

☐Y☐N Are you currently having dental discomfort? If yes, explain:

☐Y☐N Are your teeth sensitive? ☐to cold ☐to hot ☐to sweets ☐when biting

What factors are most important for your satisfaction with our office?

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (Updated 2015)

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____ **Date:**_____

☐ I give permission for the following communications to be used by Dr. Antonio Lopez-Ibarra **(please check all that apply)** :
☐ Cell phone: ☐Text Message reminders permitted ☐ E-Mail: ☐ Home phone ☐ Work

☐ I am granting permission for Dr. Antonio Lopez-Ibarra to leave a message with any person who may answer my phone or on my voicemail of the following numbers **(please check all that apply)**:
☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back ☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children as well:

MEDICAL HISTORY

GENERAL HEALTH: ☐EXCELLENT ☐GOOD ☐FAIR ☐POOR PRIMARY PHYSICIAN:

☐Y☐N Under a physician's care now?
☐Y☐N Any hospitalization in the past 5 years?
☐Y☐N Any serious illnesses/surgeries?
☐Y☐N Use tobacco in any form? If Yes, Type:
☐Y☐N Is pre-medication required before dental visits due to heart condition or artificial joint?
☐Y☐N Taking any prescription or daily OTC medications/drugs? *If yes, list details in the Medication Section.*

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date:

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ACID REFLUX
☐ADHD
☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ANXIETY
☐ARTIFICIAL HEART VALVE
☐ARTIFICIAL JOINTS
☐ARTHRITIS
☐ASTHMA
☐AUTISM/ASPERGER'S
☐BLEEDING DISORDER
☐BULIMIA
☐CANCER/MALIGNANCY
☐CEREBRAL PALSY
☐CHEMICAL DEPENDENCY
☐CONVULSIONS
☐DEPRESSION
☐DIABETES
☐DIZZINESS/FAINTING
☐EPILEPSY/SEIZURES
☐FREQUENT EAR INFECTIONS
☐FREQUENT HEADACHES
☐HEARING PROBLEMS
☐HEART ATTACK
☐HEART DISEASE
☐HEART MURMUR
☐HEPATITIS
☐HIGH BLOOD PRESSURE
☐KIDNEY DISEASE
☐LIVER PROBLEMS
☐MITRAL VALVE PROLAPSE
☐MONONUCLEOSIS
☐PACEMAKER
☐OTHER – PLEASE LIST:
☐PSYCHIATRIC TREATMENT
☐RADIATION/CHEMO
☐RESPIRATORY DISEASE
☐RHEUMATIC FEVER
☐SINUS PROBLEMS
☐STROKE
☐THYROID CONDITION
☐TUBERCULOSIS
☐ULCERS

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

☐ASPIRIN
☐ANESTHETIC – LOCAL
☐BARBITURATES
☐CODEINE
☐DAIRY
☐LATEX
☐LACTOSE INTOLERANCE
☐METAL SENSITIVITY
☐NITROUS OXIDE SEDATION
☐SLEEPING PILLS
☐SULFA DRUGS
☐PENICILLIN/OTHER ANTIBIOTICS
☐NONE
☐OTHER – PLEASE LIST:

MEDICATION INFORMATION

ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐NONE

☐ANTIBIOTICS/SULFA DRUGS
☐BLOOD THINNERS
☐INSULIN
☐OTHER DIABETIC MEDICATIONS
☐OTHER (PLEASE LIST BELOW)
☐ANTIHISTAMINES/ALLERGY
☐CANCER/CHEMO MEDICATIONS
☐NITROGLYCERIN
☐RECREATIONAL DRUGS
☐DAILY ASPIRIN
☐CORTISONE/STEROIDS
☐ORAL CONTRACEPTIVES
☐THYROID MEDICATIONS
☐BLOOD PRESSURE MEDICATIONS
☐HEART MEDICATION/DIGITALIS
☐OSTEOPOROSIS MEDICATIONS
☐TRANQUILIZERS

DRUG NAME (OR WE CAN COPY YOUR LIST)	DOSAGE	REASON PRESCRIBED

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Financial Guidelines

We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.

Insurance

We accept all major dental insurance payments, however we may not be an in network provider for your plan. If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

We are in network for Delta Dental, Cigna, Aetna, Assurant, Premera, United and many other insurances. We will gladly bill most insurances for you.

No estimate is a guarantee of payment. Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

I certify that I, and/or my dependent(s), have insurance coverage with _____ insurance and assign directly to Tri City Dental Care 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.

Tri City Dental Care may use my health care information and may disclose such information only to the above named insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Payments

- **As you know, dental insurance does not cover all the cost of your treatment. For your convenience, we offer the following payment options:**
  - Cash, check, and all major credit cards are accepted (Visa, MasterCard, Discover)
  - 5% Discount for our uninsured cash/check paying patients
  - Care Credit Monthly Payment Plan (This is a line of credit which is used for health care expenses. Care credit offers low monthly payments and approval takes only a few minutes. We will gladly help you with the application. They have NO interest 6 or 12 month options.)
- **Balances left over 90 days will incur an 18% or $10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

Short Cancelled/ Missed Appointments

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short canceled or missed appointments** will be charged $50 per appointment.
- **By signing below I acknowledge I have read and understand the guidelines above.**

Signature: Date: