

## CONSENT TO DENTAL TREATMENT

DENTIST: Matthew Kelley DDS

PATIENT: \_\_\_\_\_

1. I request and authorize the above listed provider of service, and/or such other persons as he may appoint to perform or assist in the performance of the dental treatment or procedures indicated during my exam. I understand that there have been no guarantees given or implied of any sort by anyone as to the results that may be obtained.
2. I understand that treatment or procedures may involve some risks.
3. As an alternative to this therapy, I may elect to alternate treatment.
4. I also understand that failure to treat this condition will result in a non-treated outcome.
5. Further, it is understood that unforeseen conditions or circumstances may arise during the course of my procedures or alternate treatment. Therefore, I consent to and authorize the performance of any care, procedures or treatment not specified by the dentist but that he believes is necessary or advisable as a result of these unforeseen events or conditions.
6. I consent to the administration of any anesthetic that the dentist or his hygienist deems necessary to provide proper treatment.
7. I understand that there are risks involved with the administration of anesthesia. The alternative to the use of these anesthetics is not having any anesthesia.
8. I have been given an opportunity to refuse to consent to any and all treatment or procedures specified in this form and have indicated my exclusions by drawing a line through the objectionable word (s), sentence (s), or paragraph (s), and writing my initials next to the portion to which I refuse to consent. I am also free to indicate at the end of this form, anything not mentioned herein, but to which I refuse to consent.

I certify that I have read and understand the above. I accept all risk of, if any, in hope of obtaining the desired beneficial results. I acknowledge that the dentist has explained all of the above to me in a manner to allow me to comprehend the consequences of my actions. Any questions about this treatment plan and its attendant risks have been answered fully and to my complete satisfaction.

\_\_\_\_\_

Patient/Guardian

Date

## FINANCIAL POLICY

We feel strongly that our patients deserve the best care. In an effort to provide high quality care, we would like to share information with you about financing health care. We hope that by providing you with the following information, we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us.

1. We ask that you pay in full at your first visit. If you have insurance, please pay that portion which insurance does not cover. We accept **VISA, MasterCard, Discover, American Express and Care Credit** for your convenience.
2. Remember that, if you have insurance, the insurance contract is between the patient and the insurance company. The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but we cannot guarantee your benefits. If your insurance provider informs us of benefits that you are entitled to, we will advise you of the same, however we cannot be responsible for inaccurate information provided by your insurance company, or for payment or nonpayment of claims.
3. Within 30 days of service, the balance should be paid in full. Compounded Interest will be charged at 18% per year (1.5% per month) on balances over 30 days past due.
4. Many insurance plans cover a certain percentage of the fees. Normally, the insurance company will cover the "usual and customary fees". These benefits are determined by how much your employer paid for the plan. Your insurance, as a result, may cover less than you thought they might have. Please be familiar with the benefits provided by your plan.
5. For our patients without insurance coverage, we offer a 7% discount for services paid by cash or check. Seniors (65 years and older) without insurance are eligible for a 10% discount if paid in full by cash or check at the time of service.
6. The age of majority is 18 years old. The parent that brings in the minor child is responsible for payment.
7. Past due accounts will be sent to a collection agency at our discretion. We charge **\$25** for returned checks.
8. If you find it necessary to reschedule or cancel an appointment, please contact us **2 business days (M-Th) in advance** so that your time may be utilized by another patient in need. Failed appointments, as well as, appointments changed or cancelled without 2 business days' notice will result in a **\$50 charge per hour for hygiene visits and \$100.00 charge per hour for any visit for dental treatment.** \_\_\_\_\_ **(Please read and initial)**

I authorize insurance benefits to be paid directly to Dr. Kelley. I also give permission for the doctor to release information in order to process the claim. I agree that I am responsible for all unpaid balances.

**Signature:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_  
First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient)

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

Section 2

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

Additional Comments:

Section 3

Primary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

Secondary Insurance Information

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ City, State, Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**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 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 \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  Yes  No \_\_\_\_\_
- Are you on a special diet?  Yes  No
- Do you use tobacco?  Yes  No
- Do you use controlled substances?  Yes  No

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

Are you allergic to any of the following?  
 Aspirin  Penicillin  Codeine  Local Anesthetics  Acrylic  Metal  Latex  Sulfa drugs  
 Other If yes, please explain: \_\_\_\_\_

- Do you have, or have you had, any of the following?
- |  |  |  |   |
|--|--|--|---|
| AIDS/HIV Positive <input type="radio"/> Yes <input type="radio"/> No         | Cortisone Medication <input type="radio"/> Yes <input type="radio"/> No      | Hemophilia <input type="radio"/> Yes <input type="radio"/> No            | Radiation Treatments <input type="radio"/> Yes <input type="radio"/> No       |
| Alzheimer's Disease <input type="radio"/> Yes <input type="radio"/> No       | Diabetes <input type="radio"/> Yes <input type="radio"/> No                  | Hepatitis A <input type="radio"/> Yes <input type="radio"/> No           | Recent Weight Loss <input type="radio"/> Yes <input type="radio"/> No         |
| Anaphylaxis <input type="radio"/> Yes <input type="radio"/> No               | Drug Addiction <input type="radio"/> Yes <input type="radio"/> No            | Hepatitis B or C <input type="radio"/> Yes <input type="radio"/> No      | Renal Dialysis <input type="radio"/> Yes <input type="radio"/> No             |
| Anemia <input type="radio"/> Yes <input type="radio"/> No                    | Easily Winded <input type="radio"/> Yes <input type="radio"/> No             | Herpes <input type="radio"/> Yes <input type="radio"/> No                | Rheumatic Fever <input type="radio"/> Yes <input type="radio"/> No            |
| Angina <input type="radio"/> Yes <input type="radio"/> No                    | Emphysema <input type="radio"/> Yes <input type="radio"/> No                 | High Blood Pressure <input type="radio"/> Yes <input type="radio"/> No   | Rheumatism <input type="radio"/> Yes <input type="radio"/> No                 |
| Arthritis/Gout <input type="radio"/> Yes <input type="radio"/> No            | Epilepsy or Seizures <input type="radio"/> Yes <input type="radio"/> No      | High Cholesterol <input type="radio"/> Yes <input type="radio"/> No      | Scarlet Fever <input type="radio"/> Yes <input type="radio"/> No              |
| Artificial Heart Valve <input type="radio"/> Yes <input type="radio"/> No    | Excessive Bleeding <input type="radio"/> Yes <input type="radio"/> No        | Hives or Rash <input type="radio"/> Yes <input type="radio"/> No         | Shingles <input type="radio"/> Yes <input type="radio"/> No                   |
| Artificial Joint <input type="radio"/> Yes <input type="radio"/> No          | Excessive Thirst <input type="radio"/> Yes <input type="radio"/> No          | Hypoglycemia <input type="radio"/> Yes <input type="radio"/> No          | Sickle Cell Disease <input type="radio"/> Yes <input type="radio"/> No        |
| Asthma <input type="radio"/> Yes <input type="radio"/> No                    | Fainting Spells/Dizziness <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat <input type="radio"/> Yes <input type="radio"/> No   | Sinus Trouble <input type="radio"/> Yes <input type="radio"/> No              |
| Blood Disease <input type="radio"/> Yes <input type="radio"/> No             | Frequent Cough <input type="radio"/> Yes <input type="radio"/> No            | Kidney Problems <input type="radio"/> Yes <input type="radio"/> No       | Spina Bifida <input type="radio"/> Yes <input type="radio"/> No               |
| Blood Transfusion <input type="radio"/> Yes <input type="radio"/> No         | Frequent Diarrhea <input type="radio"/> Yes <input type="radio"/> No         | Leukemia <input type="radio"/> Yes <input type="radio"/> No              | Stomach/Intestinal Disease <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem <input type="radio"/> Yes <input type="radio"/> No         | Frequent Headaches <input type="radio"/> Yes <input type="radio"/> No        | Liver Disease <input type="radio"/> Yes <input type="radio"/> No         | Stroke <input type="radio"/> Yes <input type="radio"/> No                     |
| Bruise Easily <input type="radio"/> Yes <input type="radio"/> No             | Genital Herpes <input type="radio"/> Yes <input type="radio"/> No            | Low Blood Pressure <input type="radio"/> Yes <input type="radio"/> No    | Swelling of Limbs <input type="radio"/> Yes <input type="radio"/> No          |
| Cancer <input type="radio"/> Yes <input type="radio"/> No                    | Glaucoma <input type="radio"/> Yes <input type="radio"/> No                  | Lung Disease <input type="radio"/> Yes <input type="radio"/> No          | Thyroid Disease <input type="radio"/> Yes <input type="radio"/> No            |
| Chemotherapy <input type="radio"/> Yes <input type="radio"/> No              | Hay Fever <input type="radio"/> Yes <input type="radio"/> No                 | Mitral Valve Prolapse <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis <input type="radio"/> Yes <input type="radio"/> No                |
| Chest Pains <input type="radio"/> Yes <input type="radio"/> No               | Heart Attack/Failure <input type="radio"/> Yes <input type="radio"/> No      | Osteoporosis <input type="radio"/> Yes <input type="radio"/> No          | Tuberculosis <input type="radio"/> Yes <input type="radio"/> No               |
| Cold Sores/Fever Blisters <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur <input type="radio"/> Yes <input type="radio"/> No              | Pain in Jaw Joints <input type="radio"/> Yes <input type="radio"/> No    | Tumors or Growths <input type="radio"/> Yes <input type="radio"/> No          |
| Congenital Heart Disorder <input type="radio"/> Yes <input type="radio"/> No | Heart Pacemaker <input type="radio"/> Yes <input type="radio"/> No           | Parathyroid Disease <input type="radio"/> Yes <input type="radio"/> No   | Ulcers <input type="radio"/> Yes <input type="radio"/> No                     |
| Convulsions <input type="radio"/> Yes <input type="radio"/> No               | Heart Trouble/Disease <input type="radio"/> Yes <input type="radio"/> No     | Psychiatric Care <input type="radio"/> Yes <input type="radio"/> No      | Venereal Disease <input type="radio"/> Yes <input type="radio"/> No           |
|  |  |  | Yellow Jaundice <input type="radio"/> Yes <input type="radio"/> No            |

Have you ever had any serious illness not listed above?  Yes  No \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

# DENTAL HISTORY

Referred by \_\_\_\_\_ How would you rate the condition of your mouth?  Excellent  Good  Fair  Poor  
 Previous Dentist \_\_\_\_\_ How long have you been a patient? \_\_\_\_\_ Months/Years  
 Date of most recent dental exam \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of most recent x-rays \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Date of most recent treatment (other than a cleaning) \_\_\_\_/\_\_\_\_/\_\_\_\_  
 I routinely see my dentist every:  3 mo.  4 mo.  6 mo.  12 mo.  Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? \_\_\_\_\_

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

YES NO

## PERSONAL HISTORY



1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [ ] \_\_\_\_\_  YES  NO
2. Have you had an unfavorable dental experience? \_\_\_\_\_  YES  NO
3. Have you ever had complications from past dental treatment? \_\_\_\_\_  YES  NO
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? \_\_\_\_\_  YES  NO
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? \_\_\_\_\_  YES  NO
6. Have you had any teeth removed? \_\_\_\_\_  YES  NO

## SMILE CHARACTERISTICS



7. Is there anything about the appearance of your teeth that you would like to change? \_\_\_\_\_  YES  NO
8. Have you ever whitened (bleached) your teeth? \_\_\_\_\_  YES  NO
9. Have you felt uncomfortable or self-conscious about the appearance of your teeth? \_\_\_\_\_  YES  NO
10. Have you been disappointed with the appearance of previous dental work? \_\_\_\_\_  YES  NO

## BITE AND JAW JOINT



11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) \_\_\_\_\_  YES  NO
12. Do you / would you have any problems chewing gum? \_\_\_\_\_  YES  NO
13. Do you / would you have any problems chewing bagels, baguettes, protein bars, or other hard foods? \_\_\_\_\_  YES  NO
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? \_\_\_\_\_  YES  NO
15. Are your teeth crowding or developing spaces? \_\_\_\_\_  YES  NO
16. Do you have more than one bite and squeeze to make your teeth fit together? \_\_\_\_\_  YES  NO
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? \_\_\_\_\_  YES  NO
18. Do you clench your teeth in the daytime or make them sore? \_\_\_\_\_  YES  NO
19. Do you have any problems with sleep or wake up with an awareness of your teeth? \_\_\_\_\_  YES  NO
20. Do you wear or have you ever worn a bite appliance? \_\_\_\_\_  YES  NO

## TOOTH STRUCTURE



21. Have you had any cavities within the past 3 years? \_\_\_\_\_  YES  NO
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? \_\_\_\_\_  YES  NO
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? \_\_\_\_\_  YES  NO
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? \_\_\_\_\_  YES  NO
25. Do you have grooves or notches on your teeth near the gum line? \_\_\_\_\_  YES  NO
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? \_\_\_\_\_  YES  NO
27. Do you get food caught between any teeth? \_\_\_\_\_  YES  NO

## GUM AND BONE



28. Do your gums bleed when brushing or flossing? \_\_\_\_\_  YES  NO
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? \_\_\_\_\_  YES  NO
30. Have you ever noticed an unpleasant taste or odor in your mouth? \_\_\_\_\_  YES  NO
31. Is there anyone with a history of periodontal disease in your family? \_\_\_\_\_  YES  NO
32. Have you ever experienced gum recession? \_\_\_\_\_  YES  NO
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? \_\_\_\_\_  YES  NO
34. Have you experienced a burning sensation in your mouth? \_\_\_\_\_  YES  NO

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**ACKNOWLEDGEMENT  
OF**

**PRIVACY PRACTICES**

**Matthew Kelley, DDS, PLLC  
21909 64<sup>th</sup> Ave W  
Mountlake Terrace, WA 98034  
425-771-3505**

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this can and will be used to:

- ! Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ! Obtain payment from third-party payers for my health care services
- ! Conduct normal health care operations such as quality assessment and improvement activities

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 my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: \_\_\_\_\_

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

Signature: \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

\_\_\_\_\_  
\_\_\_\_\_