Welcome

Thank you for choosing our practice. Please fill out this form as completely as you can. If you have any questions we'll be glad to help. (Please print)

ROBERT E STOVER, DDS, MS • 128 Lilly Rd NE, Ste 125 • OLYMPIA, WA 98506 • (360) 456-1200

PATIENT INFORMATION

Name_____ [ ] Dr. [ ] Mr. [ ] Mrs. [ ] Ms. [ ] Rev. [ ] Other:
First MI Last

Address_____ Occupation:_____ [ ] Male [ ] Female

City_____ State_____ Zip_____ Hm# (___)_____

Employer_____ Wk# (_____)_____ Ext_____ Cell # (_____)_____

Are you: [ ] Minor [ ] Married [ ] Single [ ] Divorced [ ] Widowed [ ] Separated

DOB:____/____/_____ SSN#_____ E-mail_____@_____

Spouse's Name_____ Work phone_____ Ext_____
First MI Last (if different)

Is patient a full time student? [ ] No [ ] Yes: Name of school: _____

RESPONSIBLE PARTY (if different than patient)

Name _____
First MI Last

Address _____

City_____ State_____ Zip _____

Hm# (____) _____

DOB____/_____/_____ SSN# _____

Relationship to Patient: _____

YOUR PREFERENCES

Do you prefer appointment reminders by:
[ ] Email [ ] Phone [ ] Text

Do you prefer to receive calls from our office at:
[ ] Home [ ] Work [ ] Cell

Whom may we thank for referring you?

How do you wish to be addressed by our staff?

INSURANCE INFORMATION

Medical Insurance:
Subscriber's Name:_____ Relationship to Patient: _____

DOB:_____/_____/_____ Subscriber's SSN#_____ Ins Phone # _____

Insurance Company_____ Policy #_____ Group # _____

Supplemental Insurance (Dental)
Subscriber's Name:_____ Relationship to Patient: _____

DOB:_____/_____/_____ Subscriber's SSN#_____ Ins Phone # _____

Insurance Company_____ Policy #_____ Group # _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? [ ] Yes [ ] No If yes, please complete the following:

Subscriber's Name:_____ Relationship to Patient: _____

DOB:_____/_____/_____ Subscriber's SSN#_____ Ins Phone # _____

Insurance Company_____ Policy #_____ Group # _____

MEDICAL HISTORY and CONSENT

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

Allergies

Anaphalaxis	Y	N
Latex	Y	N
Local Anesthetics	Y	N
Penicillin	Y	N
Metal	Y	N
Sulpha	Y	N
Ativan/Valium	Y	N
Asprin	Y	N
Codeine	Y	N
Sulfites	Y	N

List other known allergies:

_____

Do you take:

Blood Thinner	Y	N
Diet Pills	Y	N
Herbal Supplements	Y	N
Bisphosphonates	Y	N
Tranquilizers, Sleeping Pills, Anti-Depressants or Narcotics Regularly?	Y	N

Cardiovascular

Artificial Heart Valve	Y	N
Coronary Artery Disease	Y	N
Chest Pain or Angina	Y	N
Congestive Heart Failure	Y	N
Heart Attack	Y	N
Heart Murmur	Y	N
High Blood Pressure	Y	N
High Cholesterol	Y	N
Irregular Heart Beat	Y	N
Low Blood Pressure	Y	N
Mitral Valve Prolapse	Y	N
Pacemaker	Y	N
Tachycardia	Y	N

Endocrine

Diabetes	Y	N
Gout	Y	N
Hormonal Change	Y	N
Thyroid problems	Y	N

Eyes, Ears, Nose and Throat

Change in Hearing	Y	N
Change in Vision	Y	N
Dysphagia	Y	N
Ear Pain	Y	N
Glaucoma	Y	N
Hay Fever	Y	N
Nasal Obstruction	Y	N
Nose Bleeding	Y	N
Sinus Problems	Y	N
Tonsillectomy	Y	N
Tinnitus (Ringing)	Y	N

Gastrointestinal

Acid Reflux	Y	N
GERD	Y	N
Soft or Special Diet	Y	N
Ulcers	Y	N

Genitourinary

Frequent Urination	Y	N
Kidney disease	Y	N
Nocturia	Y	N
Dialysis	Y	N
Immunosuppressed	Y	N
Immune Systems	Y	N

General

Current weight:_____lbs

Height:_____ft_____in

Cancer	Y	N
Fatigue/Tired	Y	N
General Weakness	Y	N
Headaches	Y	N
HIV/AIDS	Y	N
Knee/hip replacement	Y	N
Liver problems	Y	N
Recent Trauma or Injury	Y	N
Rheumatic Fever	Y	N
Radiation Treatment	Y	N
Weight Change	Y	N
Contagious Diseases	Y	N

Hematological

Bleeding problems	Y	N
Hepatitis	Y	N
Blood Transfusion	Y	N
Blood Disorder (Anemia)	Y	N

Oral

Bleeding gums	Y	N
Dry mouth	Y	N
Jaw problems (TMJ)?	Y	N
Clicking?	Y	N
Pain?	Y	N
Difficulty swallowing?	Y	N
Difficulty chewing?	Y	N
Orthodontics/Invisalign	Y	N
Periodontal Disease	Y	N
Teeth clenching	Y	N
Teeth grinding	Y	N
Tooth pain	Y	N
Wisdom teeth extraction	Y	N

Do you wear removable teeth? Y N

Do you take or need antibiotics before dental procedures? Y N

Musculoskeletal

Back Pain	Y	N
Fibromyalgia	Y	N
Joint Pain	Y	N

Neurological

Alzheimer's Disease	Y	N
Dizziness	Y	N
Fainting	Y	N
Memory Loss	Y	N
Multiple Sclerosis (MS)	Y	N
Muscle Weakness	Y	N
Seizures	Y	N
Stroke	Y	N
Tingling/Numbness	Y	N
Trigeminal Neuralgia	Y	N
Tremor	Y	N

Psychiatric

ADD/ADHD	Y	N
Anxiety	Y	N
Chemical Dependency	Y	N
Depression	Y	N
Eating disorders	Y	N
Excessive Stress	Y	N
Memory problems	Y	N

Respiratory

Asthma	Y	N
Bronchitis	Y	N
Breathing problems	Y	N
Chest Pressure	Y	N
Congestion	Y	N
Dyspnea(shortness of breath)	Y	N
Emphysema	Y	N
Orthopnea	Y	N
Pneumonia	Y	N
Pulmonary Embolism	Y	N
Tuberculosis	Y	N

Sleep

Daytime Sleepiness	Y	N
Morning headaches	Y	N
Obstructive Sleep Apnea	Y	N
Do you use a CPAP?	Y	N

How often? _____

Has anyone told you that you snore? Y N

Social History

Do you smoke? Y N

__ packs a day

Do you use smokeless tobacco? Y N

Do you consume alcoholic beverages?

_____Drinks per day/week/month

Do you use recreational drugs? Y N

CONFIDENTIAL

Robert E. Stover, DDS, MS

MEDICAL HISTORY and CONSENT

List any medications you are taking:

	Medication	Dosage/Freq.	Prescriber	Reason
1.				
2.				
3.				
4.				
5.				
6.				

List any surgeries or hospitalizations you have had:

Date(year)	Surgery	Surgeon	Reason

Have there been any changes in your general health in the past year? [ ] Yes [ ] No _____

Do you have unhealed/recurrent injuries or inflamed areas, growths or sore spots in or around your mouth? [ ] Yes [ ] No

If yes please explained _____

Do you have prosthetic joint / implant? If so, describe where _____

Primary Physician's Name:_____ Physician's phone #: _____

Are you under the care of other physicians? If so, please list:

Physician	Phone #	Reason

BP:_____ Pulse:_____ Resp:_____ Reviewed By:_____ Date: _____

GENERAL CONSENT TO DIAGNOSE AND TREAT: The undersigned hereby authorizes Robert E Stover, DDS, MS to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate to make a thorough diagnosis of the undersigned patient's dental condition and needs. I authorize Robert E Stover, DDS, MS to perform any and all forms of treatment, medication, and therapy that may be necessary and further consent that Robert E Stover, DDS, MS choose and employ such assistance as deemed necessary. I understand that the use of local anesthetics agents embodies certain risk and consent to their use as deemed appropriate by Robert E Stover, DDS, MS. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my/ the patient's health. It is my responsibility to inform the dental office of any change in medical health or status.

FINANCIAL CONSENT: I understand that responsibility for payment of services provided in this office for myself and my dependent(s) is mine, due and payable at the time services are rendered. I understand that I am responsible for any portion of fees for services rendered not covered by my dental or medical insurance (if any). I further consent to and agree to pay a 1 1/2% finance charge (18% annually) that will be applied to any balance over 30 days. I acknowledge that I am responsible for all fees necessary to collect my account. I authorize Robert E Stover, DDS, MS and his staff to verify insurance coverage, if any, to submit claims and provide my insurance company with information required for a claim, to assign benefits payable to him, and to handle any necessary claim appeal(s) on my behalf.

Consent (adult):

Name of Patient _____ _____ **Date**_____

Signature of Patient

Consent (for a minor child):

Name of Parent/Guardian _____ _____ **Date**_____

Signature of Parent/Guardian

OLYMPIA PROSTHODONTICS
& COSMETIC DENTISTRY
EXCELLENCE BY CHOICE

Financial and Insurance

We strongly believe that everyone deserves quality dental care and should not feel that you have to compromise your treatment due to financial limitations. Our office manager will work with you to be able to finance the treatment you desire.

Insurance coverage for prosthodontics varies. Your benefits depend on many factors, including the payment of a deductible and the type of policy you have.

Due to initial lab costs and an effort to keep our fees low, it is our office policy not to accept in network insurance. **Please understand we will do everything possible to help you obtain the maximum benefits your policy allows**. Most insurance companies pay a percentage of the usual and customary fees. This may not always be the same as the charges for the services rendered. The best way to determine what your insurance will cover is to submit a pre-treatment estimate. We will be glad to take care of this for you at the time of your treatment consultation.

We will be happy to quote the approximate fee for your first appointment when you phone to schedule. As full treatment fees are based on each individual's particular needs, we are not able to give you a full cost estimate until after you have had an comprehensive oral examination in our office so we know what your needs are.

It is our commitment to provide the highest quality of care to all our patients and to provide options that make this care affordable. To keep rising health care costs down it is our policy to collect payment at time of services.

However, we understand at certain times other financial arrangements need to be made. Because your dental health is important to us, we offer CareCredit or Lending Club, a low interest and/or no interest monthly payment program specifically designed to pay for healthcare and elective treatment not covered by insurance.

Methods of payment

Cash or Check Payments

We offer a 5% discount for all balances paid in full of cash or check **IF** you do **NOT** have any insurance. A $65.00 fee will be charged for all returned checks.

Credit Cards

We gladly accept payments made with Visa, MasterCard, American Express, Discover cards and debit cards. No discount can be given for credit/ debit card transactions as the vendors charge us a fee.

Cancellation Fee

We are committed to seeing our patients on time and respecting of their time. Late cancellations, failed appointments and late arrivals are disruptive to other patients who are waiting to come in. In order to maintain our schedule, we request 48 hours' notice for cancellations and rescheduling of appointments. A $75.00 fee per appointment hour will be charged to the patients account.

Patient Signature_____ Date _____

OLYMPIA PROSTHODONTICS & COSMETIC DENTISTRY
EXCELLENCE BY CHOICE
ROBERT STOVER, DDS, MS
BOARD CERTIFIED PROSTHODONTIST

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Olympia Prosthodontics & Cosmetic Dentistry
128 Lilly Rd NE, Ste 125
Olympia, WA 98506
360.456.1200

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

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

Patient Name:_____ Date:_____

Signature: _____

Relationship to Patient: _____

Dependent family member also covered by this acknowledgment:

_____

May we discuss treatment with:

☐ All family members ☐ Spouse only ☐ None Other:_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

☐ The patient refused ☐ Communication barriers ☐ Emergency situation ☐ Other