Jonny Fisher DDS

Excellence in Dentistry

Patient Information

Name: ____ Date: ____________
Last First (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child

Social Security #: ______________ Driver's License #: ______________ Birth Date: ____/____/______

Phone ☐ (Home): ____________ ☐ (Work): ____________ ☐ (Cell): ______________ *(mark best contact)*

Email: ______________________________ How do you prefer reminders? email text phone mail

Home/Mailing Address: ____
Street City, State Zip Code

Responsible Party

The following is for: ☐ patient's spouse ☐ patient's parent ☐ other: ______________________

Name: ____ Date: ____________
Last First (Preferred Name/Nickname)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other ______________________

Social Security #: ______________ Driver's License #: ______________ Birth Date: ____________

Phone ☐ (Home): ____________ ☐ (Work): ____________ ☐ (Cell): ____________ *(mark best contact)*

Home Address: ______________________ Mailing Address: ______________________________

____
City State Zip Code

Dental Insurance

Name of Subscriber: ________________________________ Subscriber's Birth Date: ____________
Last First MI

Social Security#: ____________________ Plan ID #: ________________ Group #: ____________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ____

Employer Address: ____
Street City State Zip Code

Insurance Plan: ______________________ Claims Mailing Address: ______________________

____
City State Zip Code

Do you have additional insurance? If so, please complete the following section:

Name of Subscriber: ________________________________ Subscriber's Birth Date: ____________
Last First MI

Social Security#: ____________________ Plan ID #: ________________ Group #: ____________

Subscriber's Address: ____
Street City State Zip Code

Subscriber's Employer Name: ____

Employer Address: ____
Street City State Zip Code

Insurance Plan: ______________________ Claims Mailing Address: ______________________

____
City State Zip Code

HEALTH HISTORY

Patient Name:_________________________________ Birth Date:__________________ Phone:_____________________

How can we help you today?______________________________ How did you hear about us?___________________________

Yes No Are you in pain now? If so, please note severity (*10-most extreme*) 0 1 2 3 4 5 6 7 8 9 10

Yes No Has there been a change in your health within the last three years? If yes, please describe.____________________

____

Yes No Are you currently being treated by a physician? If so, for what? ___________________________________

Yes No Have you had problems with prior dental treatment? If yes, please explain. ___________________________

____

PLEASE CIRCLE ANY YOU *HAVE* OR *EVER HAD*:

Heart disease Heart attack Heart defects

High blood pressure Stroke Prolonged bleeding

Diabetes Hepatitis Cancer HIV

Asthma emphysema TB other lung disease

Radiation treatments Chemotherapy

Artificial joints Prosthetic heart valve

Allergies to any: foods medications latex metals

CURRENT MEDICATIONS & INDICATIONS:

1.
2.
3.
4.
5.
6.

HAVE YOU EVER OR ARE YOU CURRENTLY TAKING:

Yes No Medications, over-the-counter medicines (including Aspirin), or natural remedies? (Please list in the box above)

Yes No Alcohol? If yes, how often? ______________________________ Day/week

Yes No Tobacco? If yes, how often? ______________________________ Day/week

Yes No Recreational Drugs? If yes, how often? ______________________________ Day/week

Yes No Antibiotics/premedication for dental appointments?

Yes No "Bisphosphonates" for bone strengthening or osteoporosis (*Fosomax*, *Boniva*, *Actonel, etc.*)

WOMEN:

Yes No Are you or could you be pregnant or nursing?

Yes No Are you taking birth control pills?

To the best of my knowledge, I have answered all questions completely & accurately. I will inform my dentist of any change in my health and/or medications**. I understand that I am financially responsible for all charges, whether or not paid by insurance & that Payments are due in full at the time of treatment** (unless prior arrangements have been made).

Patient's signature:________________________________ Date:______________ Provider Review:____________________

ANNUAL REVIEW OF HEALTH HISTORY:

Patient's signature:________________________________ Date:______________ Provider Review:______________

Patient's signature:________________________________ Date:______________ Provider Review:______________

Patient's signature:________________________________ Date:______________ Provider Review:______________

Patient's signature:________________________________ Date:______________ Provider Review:______________

PROVIDER'S REVIEW:

Date	BP & HR	Significant Medical Findings / Provider Notes

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Payment Policy

- **Payment is due** at the time of treatment.
- We accept cash, checks, and major credit cards.
- We also accept the Care Credit payment plan that allows you to start treatment today and spread the payments over time (there is no fee to apply and the application usually takes only a few minutes).
- **You are responsible for the full amount** of treatment rendered, regardless of benefits covered by your dental plan.
- If you have current coverage through a dental plan, they may help offset the cost of treatment. As a courtesy, we generally bill your dental plan provider on your behalf.
- We ask for at least **24 hour notice** to cancel or reschedule your appointment; otherwise a **$100.^{00} fee** may be assessed to your account.

Cancellation Policy

- When you schedule an appointment with us, that time is set aside **specifically for you**.
- **All appointments** made by you are considered "**confirmed**".
- Please give us **24 hour notice** if you need to cancel or reschedule an appointment.
- We **cannot accept cancellations** outside of normal office hours.
- Appointments cancelled less than 24 hours or missed appointments are subject to a **$100.^{00} fee** assessed to your account.
- All cancellation fees must be paid **prior to scheduling** another appointment.

Seriously... what's the big deal?

Broken appointments or short notice cancellations can cause these significant issues:

- **You** are unable to receive the service you needed or desired.
- **The doctor and his team** are prepared with equipment & materials specific to your appointment. You waste their time & hard work.
- **Another patient** could have been scheduled in that valuable time slot and received necessary (sometimes urgent) dental treatment.

HIPAA & Notice of Privacy Practices

In accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you have certain rights to privacy regarding my protected health information. We maintain a *Notice of Privacy Practices* at our office with a complete description of the uses & disclosures of your health information. This document is available upon request.

Printed Name: ___________________________________ **Relationship to Patient: ____________**

Signature: ____ **Date: ________________________**

690 SE Bishop Blvd, Ste D
Pullman, WA 99163
(509) 332-2366

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Authorization to Release Dental Records

I hereby request & authorize ________________________________
(name of dentist/office)
to release any and all dental records for the past 7 years for the following patients:

____

____

____

____

____

Please send (preferably by email) to:

Jonny Fisher DDS
690 SE Bishop Blvd, Ste. D
Pullman, WA 99163
(509) 332-2366
TeamDrFisher@gmail.com

Name: ___________________ Signature: ____________________

Relationship to Patient: self parent spouse other: ___________