Welcome to Troy Family Dental!

We are excited to have you here in the practice as our patient.

To help us get acquainted, please answer a few short questions about yourself.

TODAY'S DATE: _______________

PATIENT NAME: _________________________________ DOB: _____________________________

EMAIL: ____ CELL/TEXT: _______________________

When was your last visit to a dentist?

____

____

Do you currently have any pain or issues in your mouth that you are concerned with today?

____

____

____

On a scale from 1 to 10 with 10 being highest how would you rate your dental health?_______________

On the same scale how important is your dental health to you?________________

If you had a magic wand and could change anything about your smile what would it be?____

Who may we thank for your referral?

Facebook	Yelp	Google
Health Fair	Insurance Company	Location
Phone Book	Web Search	

Friend/Family Member ____________________Team Member_____________________

Elect Chart ______________
(Office Use)

PATIENT INFORMATION SHEET
(Please fill out completely)

PATIENT INFORMATION: ☐ MALE ☐ FEMALE DATE:________________

Name ____ DOB: ____________ SS#__________________
Last First Mid Initial

Street Address ____
City State Zip

Mailing Address (if different)____________________________________ E-Mail*:______________________________

Home Phone __________________________________ Cell Phone* ____

Employer ____)________________________
Name Address Phone #

PARENT OR GUARDIAN INFORMATION: (All patients 17/under must have this section completed)

Name ____ Relation to Patient __________________
Last First Mid Initial

DOB: ______________ SS# ___________________________ E-Mail:_____________________________________

Home Phone (____)_____________________________ Cell Phone (_____)________________________________

Employer ____
Name Address Phone #

Do You Have Insurance? Yes ☐ No ☐

Insurance Co. Name __________________________________

Subscriber Name _____________________________________

DOB: _________________ SS#_________________________

Subscriber's Employer_________________________________

Subscriber # ____

Group # ____

Relationship ____

Secondary Insurance Co. Name _______________________

Subscriber Name ___________________________________

DOB: ____________________SS#______________________

Subscriber's Employer_______________________________

Subscriber # _______________________________________

Group # ____

Relationship _______________________________________

If you do not show for your appointment or cancel with less than 48 hours notice, a fee of $50 will be charged to your account. You will be personally responsible for this charge. I understand that responsibility for dental services provided in this office for myself or my dependents, regardless if covered by insurance, is mine.

Patient or Guardian Signature: ____ **Date:** _________________

Troy Family Dental
1118 Ocean Beach Hwy. * Longview, WA 98632 * Phone 360-423-5240 * Fax 360-501-5391

TROY FAMILY DENTAL
Financial Policy & Patient Agreement

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment. All patients must complete our Patient Information and Insurance form before being seen by the doctor.

Please Note:

- Payment Due At The Time Of Service
- We Accept Cash, Checks and Credit Cards
  (VISA, MasterCard, Discover & American Express)
- Financing available through CareCredit (Applications available)

No Show/ Short Notice Cancellation Policy

Your appointment time is important not only for you, but also to Dr. Troy and other patients who are in need of our services. **If you cannot keep your appointment for any reason, please call us 48 hours prior to your appointment time.** If you do not show for your appointment or cancel with less than 48 hours notice, a fee of $50 will be charged to your account. You will be personally responsible for this charge. This charge will not be billed to nor paid for by your insurance company.

Regarding Insurance

We have accepted assignment of dental benefits. However, we do require payment of deductibles and any portion not paid by insurance by one of the options listed above. You are responsible for any remaining balance whether your insurance company pays or not. We cannot bill your insurance unless you give us complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid in full within 90 days, the balance becomes due and payable. Delinquent accounts will bear interest at a rate of 1% per month (12% annually) on the unpaid balance.

(Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney fees and collection expense. All delinquent accounts bear interest at legal rate.)

Usual and Customary Rates / Maximum Allowable Benefit

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for treatment regardless of any insurance company's arbitrary determination of usual and customary or maximum allowable benefits.

Minor Patients

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of treatment or by one of the other options listed above.
Thank you for understanding our Financial Policy. Please let us know if you have questions or concerns.

I have read the Financial Policy and Patient Agreement. I understand and agree to the Financial Policy and Patient Agreement.

____ ______________

Patient Name (Printed) Date

____ ______________

Signature of Patient or Responsible Party (Must be 18 or older) Relation to Patient

Revised 11/26/13

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? ☐ Nursing?
☐ Taking oral contraceptives?

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

Do you have, or have you had, any of the following?

☐ AIDS/HIV Positive	☐ Chest Pains	☐ Frequent Headaches	☐ Hypoglycemia	☐ Rheumatic Fever
☐ Alzheimer's Disease	☐ Cold Sores/Fever Blisters	☐ Genital Herpes	☐ Irregular Heartbeat	☐ Rheumatism
☐ Anaphylaxis	☐ Congenital Heart Disorder	☐ Glaucoma	☐ Kidney Problems	☐ Scarlet Fever
☐ Anemia	☐ Convulsions	☐ Hay Fever	☐ Leukemia	☐ Shingles
☐ Angina	☐ Cortisone Medicine	☐ Heart Attack/Failure	☐ Liver Disease	☐ Sickle Cell Disease
☐ Arthritis/Gout	☐ Diabetes	☐ Heart Murmur	☐ Low Blood Pressure	☐ Sinus Trouble
☐ Artificial Heart Valve	☐ Drug Addiction	☐ Heart Pacemaker	☐ Lung Disease	☐ Spina Bifida
☐ Artificial Joint	☐ Easily Winded	☐ Heart Trouble/Disease	☐ Mitral Valve Prolapse	☐ Stomach/Intestinal Disease
☐ Asthma	☐ Emphysema	☐ Hemophilia	☐ Osteoporosis	☐ Stroke
☐ Blood Disease	☐ Epilepsy or Seizures	☐ Hepatitis A	☐ Pain in Jaw Joints	☐ Swelling of Limbs
☐ Blood Transfusion	☐ Excessive Bleeding	☐ Hepatitis B or C	☐ Parathyroid Disease	☐ Thyroid Disease
☐ Breathing Problem	☐ Excessive Thirst	☐ Herpes	☐ Psychiatric Care	☐ Tonsillitis
☐ Bruise Easily	☐ Fainting Spells/Dizziness	☐ High Blood Pressure	☐ Radiation Treatments	☐ Tuberculosis
☐ Cancer	☐ Frequent Cough	☐ High Cholesterol	☐ Recent Weight Loss	☐ Tumors or Growths
☐ Chemotherapy	☐ Frequent Diarrhea	☐ Hives or Rash	☐ Renal Dialysis	☐ Ulcers
				☐ Venereal Disease
				☐ Yellow Jaundice

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: ____________

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 ____________

Troy Family Dental – JD Troy DDS, PLLC

Longview, Washington 98632

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of JD Troy DDS, PLLC. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

JD Troy DDS, PLLC reserves the right to change the privacy practices that are currently described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORITY ***In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)***	
Spouse only	**___YES ___NO**
Any Member of my immediate family (Spouse, Children, Children's Spouses)	**___YES ___NO**
Any Member of my extended family: (Parents, Grandchildren)	**___YES ___NO**
Other:	
Name of Patient (please print):	
Patients Signature (if 18 years old or older):	
Patient's personal representative (please print):	
Personal Representative's signature:	
Representative's Telephone Number:	**Date:**

OFFICE USE BELOW THIS LINE

Acknowledgement not obtained

Provided Prior to Treatment? ___YES ___NO Date Statement Provided: _______________

Reason for Denial:

- ___ Needed More Time to review Statement of Privacy Practices
- ___ Wanted to Consult with another person before signing
- ___ Physically Unable to Sign
- ___ No Reason Offered
- ___ Other:_____________________________________