Troy
FAMILY DENTAL

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? _____

Have you ever had to have a deep cleaning? _____

Have you ever been told you have to take antibiotics prior to seeing 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 #

Emergency Contact _____
Name Relationship 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 within 48 business hours prior to your appointment time.** If you do not show for your appointment or cancel with less than 48 business 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.

No photography or videography without verbal permission

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

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:_____

Troy Family Dental

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

_____

Previous Dentist/Dental Office

_____

Mailing Address

_____

City, State, Zip

_____ _____

Phone # ***Fax #***

Patient Name: _____

Patient Date of Birth: _____

Please send the Following:

- ☐ Bitewing X-rays (If less than 1yr old)
- ☐ Pano/Full Mouth X-rays (If less than 5 years old)
- ☐ Periodontal Charting
- ☐ Dates of RPC (if applies) _____
- ☐ Last Date of Cleaning _____
- ☐ Treatment Findings
- ☐ Permission to send chart notes upon request

I hereby authorize the release of dental records for the above-mentioned patient to:

Troy Family Dental
JD Troy D.D.S., P.L.L.C
1118 Ocean Beach Hwy.
Longview, WA

Email: frontdesk@troyfamilydental.net

Your Name: _____ **Relation to Patient:** _____

Signature: _____ **Date:** _____

Authorization Expires 90 days from date signature is acquired.

Notice to Patients

We care about your care!

Our practice utilizes technology designed to record and capture key details of our conversation and the care provided. This system allows us to focus entirely on you by reducing the need for manual note-taking. By streamlining documentation, this technology helps us deliver a higher level of care.

Your privacy is extremely important to us. All information recorded is used solely to support your treatment and is accessible only to authorized healthcare professionals involved in your care. Our practice follows strict privacy and security standards to protect your health information.

By signing below, you acknowledge and agree to the use of this technology for documentation purposes during your appointment.

Patient Consent

I acknowledge and consent to the use of technology for documenting clinical details during my visit. I understand that this helps support my care and that my information will remain secure.

Patient Name: _____

Patient Signature: _____

Date: _____