Lasting Impressions Dentistry
Sabrina Habib Heppe DDS, PS
(206) 682-3093

Personal Information

Last Name_____ First Name_____ Pref. Name_____ MI___
Mailing Address_____ Apt # _____
City_____ State_____ Zip_____
Home# (____) _____ Cell# (____) _____ Sex: ___M ___F
E-Mail: _____ Confirmation of Apts by Email? ___ Yes ___ No
Date of Birth ___/___/___ SSN#: _____
Marital Status: ___Married ___Single ___Other_____

Parent's Name (if patient is a child)
Last Name _____ First Name _____ MI__
Date of Birth ___/___/___ SSN#: _____

Employer _____ Occupation _____ Work# (____) _____
Spouse Information (if applicable)
Last Name _____ First Name _____ MI__
Spouse Employer _____ Occupation _____ Work# (____) _____
Emergency Contact Person _____
Emergency Contact Phone#(____)_____
Names of other family members that are patients here: _____

Who may we thank for referring you to our office? _____

Dental Insurance Information

Insurance Coverage? **YES NO**
Insurance Company Name: _____ Employer _____
Group Name: _____ Group # _____
Subscriber's Name: _____ Date of Birth _____ / _____ / _____
Subcriber's ID or SSN# _____

Secondary Insurance? **YES NO**

Insurance Company Name: _____ Employer _____
Group Name: _____ Group # _____
Subscriber's Name: _____ Date of Birth _____ / _____ / _____
Subcriber's ID or SSN# _____

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Health History

Name: _____Date of Birth: _____
Physician's Name: _____ Physician's Number: _____
Please list all medications you are currently taking (including herbal/natural remedies):
_____
_____

Do you require antibiotics prior to a dental cleaning? **YES NO** Please list reason:
Please circle if you have any of the following:

HEART
Heart Attack
Heart Surgery
Heart Murmur
Mitral Valve Prolapse
Congenital Heart Defects
Pacemaker/Defibrillator
Artificial Heart Valve
Angina/chest pain
High Blood Pressure
Rheumatic fever

BLOOD
Easy Bruising
Frequent nosebleeds
Blood Disease
Blood Transfusion

ALLERGY
Hay fever
Sinus problems
Skin rashes
Take allergy meds
Asthma

DIGESTIVE
Ulcers
Special Diet
Constipation/Diarrhea
Kidney Problems
Bladder Problems
Weight gain or loss
Acid reflux

BONE/JOINT
Arthritis/ Rheumatoid
Back/Neck Pain
Joint Replacement

NERVOUS SYSTEM
Seizures
Epilepsy
History of Head Injury
Other:

DIABETES
Type I
Type II
Family History
Urinate 6+ times/day
Frequently Thirsty
Controlled with Medication

CANCER
Type:_____
Stage: I II III IV
In Remission
Chemotherapy

OTHER CONDITIONS:
Autoimmune Disorder
Stroke
Thyroid disorder
Frequent/severe Headaches
Eating Disorder
Tuberculosis
Hepatitis A
Hepatitis B or C
Liver Disease
Herpes or cold sores
HIV positive/AIDS
Glaucoma
Alcoholism
Drug Addiction
Tobacco Use
Behavioral Disorder

Please list any other medical conditions you have ever had that are not listed above:
Have you been hospitalized for any reason within the last year? **YES NO** If yes, please describe:

Do you have any allergies? Please circle
Antibiotics Aspirin Codeine Latex Local Anesthetic Sulfa Other:_____
Please describe your reaction:_____

Women:
Are you pregnant: **YES NO** Due Date: _____ Are you nursing? **YES NO**
Are you taking birth control pills? **YES NO**
(Please note that taking some antibiotics can interfere with the effectiveness of birth control pills and a second form of birth control is recommended)

To the best of my knowledge, all the preceding answers are correct. If I have any changes in my health status or if my medications change, I shall inform the dentist and staff at my next appointment.

Patient Signature:_____ Date:_____
Provider Initials: _____ Date: _____

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Dental History

Name: _____ Date of Birth: _____

Previous Dentist (name and location): _____
Date of last dental visit: _____ Date of last dental x-rays: _____
What was done at your last dental visit: _____
How often were you getting your teeth cleaned? _____
Are you in pain today? **YES NO** Location: _____

Please check all that apply:

DENTAL SYMPTOMS:

- o Chew on one side of mouth
- o Cracked or broken teeth/fillings
- o Sensitivity when biting
- o Sensitivity to hot or cold
- o Sensitivity to sweets
- o Sensitivity when brushing
- o Unhappy with the appearance of your teeth

PERIODONTAL SYMPTOMS:

- o Bleeding gums with brushing and/or flossing
- o Swollen or tender gums
- o Loose teeth
- o Tartar build-up (calculus deposits)
- o Bad breath
- o Food collection between teeth
- o Diagnosis of gum disease (periodontal disease)
- o Deep cleanings at a previous dental office

How often do you brush? _____
How often do you floss? _____
How would you rate your current dental health?
Excellent Good Fair Poor
What type of toothbrush do you currently use?
Manual Electric
What type of bristles? **Soft Med Hard**

HABITS:

- o Smoke cigarettes, pipes or cigars
- o Use smokeless tobacco
- o Bite fingernails
- o Chew ice
- o Drink more than 12 ounces of soda, juice, sports drink, or flavored coffee per day?

TMJ:

- o Grinding teeth at night
- o Clenching teeth
- o Pain or tiredness in jaw or jaw muscles
- o Pain around ear
- o Headache or pain in jaw on awakening
- o Unable to open wide
- o Unable to close jaw
- o Have night guard (and wear it nightly)
- o Previous treatment for TMJ Disorder
- o TMJ surgery

OTHER: Please write down any other significant facts about your dental history we should be aware of, including surgeries or past negative dental experiences:

_____
_____
_____
_____

Provider Inititals: _____ Date: _____

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FINANCIAL POLICY

We fully believe dental treatment is an excellent investment in an individual's physical and mental wellbeing. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that people have different needs in fulfilling their financial obligations, we do provide a number of payment options.

Payment in Full – If you do not carry dental insurance, a bookkeeping courtesy of 5% will be given for payment in full, made by cash or check at time of service. We will provide a copy of your treatment plan fees.

Payment by Cash, Check, Visa or MasterCard

In house "Payment Plan"- 50% of fee will be expected at time of service followed by 3 equal payments for the following 3 months.

Senior Citizen Discount: We offer a 5% discount to senior citizens 65 and up.

Missed or Broken Appointments: Your appointment time is reserved especially for you. To avoid a $75.00 broken appointment charge, please allow a minimum of 2 business days notice for any schedule changes. Please be aware that our work week is from Monday through Thursday, so please be sure to cancel your appointments during that timeframe.

Insurance: As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We encourage you to overview your policy in detail so you are aware of your plan specifics and maximum coverage. We can assist you in estimating you insurance benefits, but it is helpful if you have an understanding of your insurance policy prior to scheduling treatment.

Any uninsured portion is due at time of service. If your insurer denies coverage or if we do not receive payment within 60 days from your claim, the amount will then become due and payable by you.

Signature:_____ **Date:**_____

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Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Lasting Impressions Dentistry. 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.

Lasting Impressions Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed 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 health care information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	**___YES**	**___NO**
SPOUSE ONLY	**___YES**	**___NO**
OTHER(PLEASE SPECIFY)_____	**___YES**	**___NO**

_____ _____
Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

RECORD OF ACKNOWLEDGEMENT NOT OBTAINED

Provided Prior to Treatment? ___YES ___NO
Date Provided: _____
Reason for Denial: ___ NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES
___ WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING
___ UNABLE TO SIGN
___ REASON NOT GIVEN
___ OTHER (EXPLAIN):