Welcome!!

We appreciate the confidence and trust that you have placed in us and look forward to meeting you personally and professionally.

Our philosophy of care governs everything we do for you. It consists of the following key elements:

- We are truly caring about our patients and want you to feel very comfortable with our entire staff.
- We recognize that each patient is an individual and our goal is to help you retain your teeth in comfort, function and esthetics for a lifetime.
- We work with only one patient at a time, and do not double book. The time that you reserve with us is yours and yours alone.
- We strive to be thorough in everything we do, taking the time to be the best we can be.

At your first visit, we will take the time to get to know you (and you, us) and discuss your dental needs and desires. We will perform a comprehensive dental evaluation and gather information to make a customized plan for you. This will take approximately 90 minutes.

Enclosed you will find our new patient information form. Please fill this out and bring it with you to your first appointment along a list of any medications that you take.

We look forward to meeting you.

Sincerely,

Dr’s Richard and Erick Anderson

P.S. Please visit our website at www.andersonsmile.com to learn more about us!
Tell Us About You

The better we understand you, the better we can serve you. We don’t like to make assumptions or guess about what makes you tick. Please make an X along each scale below to indicate your opinion or preference.

I favor a cause-oriented approach to disease 1 1 1 1 1
I favor a treatment-oriented approach to disease

I like to be presented with more options 1 1 1 1 1
I like to be presented with fewer options

I tend to look at the big picture 1 1 1 1 1
I tend to look at the Details

I prefer long-lasting solutions which may cost more 1 1 1 1 1
I prefer more temporary solutions at lower cost

I prefer to talk in technical terms with my dentist 1 1 1 1 1
I prefer to talk in non-technical terms

My insurance determines the extent of my care 1 1 1 1 1
I largely determine the extent of my care

I prefer to wait until I must act 1 1 1 1 1
I usually see no reason to delay care

I rely more on self-maintenance 1 1 1 1 1
I rely more on professional maintenance

I like newer and more modern techniques 1 1 1 1 1
I prefer tried and true methods

I know a great deal about my dental condition 1 1 1 1 1
I know very little about my dental condition

Please check the items that are of greatest concern for you:

_____Comfort  _____Appearance  _____Function  _____Durability  _____Health  _____Money
_____Time  _____Personal Effort  _____Physical Discomfort  _____Fear / Anxiety
NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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. I also understand 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: _____________________________________________

Relationship to Patient: ___________________ Date:_______________

Signature: _________________________________________________
Facts About Dental Insurance

As an optimal-care dental practice, we strongly believe our patients deserve the best possible dental services we can provide. In an effort to maintain a high quality of care, we would like to share some facts about dental insurance with you.

**Fact #1:** Your dental insurance is based upon a contract between your employer and the insurance company. Should questions arise regarding your dental insurance benefits, it is best for you to contact your employer or the insurance company directly.

**Fact #2:** Dental insurance benefits differ greatly from traditional medical health insurance benefits and can vary quite a bit from plan to plan. When dental insurance plans first appeared in the early 1970's most plans had a yearly maximum of $1000. Today, some 30+ years later, most plans still have an annual maximum of $1000. That the premiums remained the same, allowing for a conservative yearly rate of inflation, your yearly plan maximums should be in excess of $4500 today. Your premiums have increased, but your benefits have not. Therefore, dental insurance was never set-up to cover your services 100%; it is only an aid.

**Fact #3:** You may receive a notification from your insurance company stating that dental fees are "higher than usual and customary." Insurance companies never reveal how they determine "usual, customary and reasonable" (UCR) fees. A recent survey done in the state of Washington found at least eight different UCR fee schedules for one zip code in the Seattle area. The fees are somehow determined by taking "a percentage" of an average fee for a particular procedure in a geographic area. Average has been defined as "the worst of the best" or "the best of the worst." *We do not provide average dentistry nor do we charge average fees.*

**Fact #4:** Many plans tell their participants that they will be covered "up to 80% or up to 100%," but do not clearly specify plan fee schedule allowances, annual maximums, or limitations. It is more realistic to expect dental insurance to cover 35 to 50 of major services. Remember, the amount a plan pays is determined by how much the employer paid for the plan. You get back only what your employer puts in, less the profits of the insurance company.

**Fact #5:** Many routine dental services are not covered by insurance companies. This does not mean they aren't necessary or appropriate, just not covered.

We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure that you get every benefit dollar you are entitled to. However, the treatment we recommend and *the fees we charge will always be based on your individual need, not your insurance coverage.* The ultimate decision as to what will be done and how fast we proceed will always be made by you. Based on your decision, we will discuss the total cost of treatment and what assistance you can expect from your dental insurance. All arrangements are strictly between you and our office. The full responsibility for payment of services rendered will always be with you.
Patient Information

Name__________________________ Birthdate__________________________ Soc. Sec. # _______________________

Address________________________ City__________________________ State_____ Zip____________________

Home_____________________________ Cell__________________________ Work__________________________

Circle Appropriate option: Female      Male      Single    Married    Divorced    Widowed

Patient’s or Parent’s Employer_________________________________ Work Phone____________________

Business Address________________________ City__________________________ State______ Zip________

Spouse or Parent’s Name___________________ Employer___________________ Work Phone____________________

Email address __________________________________________ Emergency Contact_____________________

Whom May We Thank for Referring You?________________________________________________________

Responsible Party

Person Responsible for Account____________________________________ Relationship to Patient____________

Address________________________________________________________ Social Security # _________________

Birthdate__________________________ Work Phone____________________ Home Phone____________________

Insurance Information

Name of Insured_____________________ Relationship to Patient____________ Insured Birthdate____________

Social Security #_________________ Employer___________________________ Insurance Co._______________

Ins. Co. Address____________________ Ins Co Phone #____________________ Group #________________

If you have secondary insurance coverage please complete the following:

Name of Insured_____________________ Relationship to Patient____________ Insured Birthdate____________

Social Security #_________________ Employer___________________________ Insurance Co._______________

Ins. Co. Address____________________ Ins Co Phone #____________________ Group #________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I consent to any advisable and necessary dental treatment to be administered by the dentist or staff for diagnostic purposes or dental restoration.

X____________________________________________________________________________________
**Patient Medical History**

Are you under medical treatment now? ............................................Y   N

Have you ever been hospitalized for any surgical operation or serious illness? ............................................Y   N

Are you taking any medication(s) including Fosomax (i.e. bisphosphonates) medications? ............................................Y   N

If yes, what medication(s) are you taking? .................................................................................................................................

Do you use tobacco? ............................................Y   N

Do you use alcohol or drugs? ............................................Y   N

Have you ever taken Phen-Fen or Redux? ............................................Y   N

Are you allergic to or had any reaction to the following?

- Local Anesthetics (e.g. novocaine) ............................................Y   N
- Penicillin or Antibiotics ............................................Y   N
- Sulfa Drugs ............................................Y   N
- Latex ............................................Y   N
- Sedatives ............................................Y   N

**Women Only:**

a) Are you pregnant ............................................Y   N

b) Are you nursing? ............................................Y   N

c) Are you taking birth control pills? ............................................Y   N

Have you ever been diagnosed with any of the following:

- AIDS/HIV
- Alzheimer’s Disease
- Anaphylaxis
- Anemia
- Angina
- Arthritis/Gout
- Artificial Heart Valve
- Artificial Joint
- Asthma
- Blood Disease
- Blood Transfusion
- Breathing Problem
- Bruise Easily
- Cancer
- Chest Pains
- Cold Sores/Fever Blister
- Congenital Heart Disorder
- Convulsions
- Cortisone Medication
- Diabetes
- Drug Addiction
- Easily Winded
- Emphysema
- Epilepsy or Seizures
- Excessive Bleeding
- Excessive Thirst
- Fainting/Dizzy
- Frequent Cough
- Frequent Headaches
- Genital Herpes
- Glaucoma
- Hay Fever
- Heart Attack/Failure
- Heart Disease
- Heart Pace Maker
- Heart Murmure
- Hepatitis A
- Hepatitis B/C
- Herpes
- High Blood Pressure
- Hives or Rash
- Irregular Heartbeat
- Kidney Problems
- Leukemia
- Liver Disease
- Low Blood Pressure
- Lung Disease
- Stomach/Intestinal Disease
- Stroke
- Mitral Valve Prolapse
- Pain in Jaw Joints
- Parathyroid Disease
- Psychiatric Care
- Radiation Treatments
- Recent Weight Loss
- Renal Dialysis
- Rheumatic Fever
- 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
- Chemotherapy
- Frequent
- Hypoglycemia
- Rheumatism
- Jaundice