Thurston Family Dental
Dr. Daryl Fedak

Date : _____

"Thank you for Selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please, take your time to fill out this form completely. If you should have any questions please do not hesitate to ask. We will be happy to help."

-Dr. Daryl Fedak and Staff-

PATIENT INFORMATION (CONFIDENTIAL)

First Name: _____ Last Name: _____

Birth Date: _____ SSN: _____ Gender: ◯ Male ◯ Female

Email: _____ Cell Phone: _____ Texting? ◯ Yes ◯ No

Address: _____

City: _____ State: _____ ZIP _____

Mailing Address: _____

City: _____ State: _____ ZIP _____

Patient's or Parent's Employer: _____ Work Phone: _____

Spouse or Parent's Name: _____ Employer: _____

Work Phone: _____ Email: _____ Cell Phone: _____

Marital Status: ◯ Minor ◯ Single ◯ Married ◯ Divored ◯ Widowed ◯ Seperated

Emergency Contact: _____ Phone: _____

How did you hear about us?

◯ Google ◯ I was referred by _____

◯ Social media ◯ Other _____

RESPONSIBLE PARTY

Name of Person Responsible for this Account: _____

Relationship to Patient: _____ Home Phone: _____

Address: _____ Work Phone: _____

Name of Employer: _____

Birthday: _____ SSN: _____

Thurston Family Dental
Dr. Daryl Fedak

INSURANCE INFORMATION

◯ No Dental Insurance ◯ Primary Insurance

Name of Insurance Company: _____

Relationship to Patient: _____ Birth Date: _____

Name of Employer: _____ Local/Union: _____

Work Phone: _____ Policy Holder Name: _____

Member ID: _____ Group: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other

Do you have Additional Insurance? ◯ Yes ◯ No **If yes, please complete the additional info below.**

SECONDARY INSURANCE INFORMATION

Name of Insurance Company: _____

Relationship to Patient: _____ Birth Date: _____

Name of Employer: _____ Local/Union: _____

Work Phone: _____ Policy Holder Name: _____

Member ID: _____ Group: _____

Insurance Company: _____ Phone: _____

Insurance Company Address: _____

Relationship to Insurance holder: ◯ Self ◯ Parent ◯ Child ◯ Spouse ◯ Other

CASH - CHECK - VISA - MASTERCARD - CARE CREDIT
PAYMENT IN FULL IS DUE AT THE TIME OF SERVICE

INSURANCE
Your insurance is a contract between you and the insurance company; it is your responsibility to know your insurance benefits.

As a courtesy; we will bill both your primary and secondary insurance companies. We will submit your claims and assist you in any way we reasonably can to help get your claims processed. In order to do this, we must receive all the information necessary to bill. If the information is not supplied you will be billed, and payment in full will be your responsibility and will be expected within 30 days of the receipt of statement.

RETURNED CHECKS
Any checks returned to our office due to non-sufficient funds (NSF) will be charged a fee of $35.

CANCELLATIONS WITH LESS THAN 2 BUSINESS DAYS NOTICE OR MISSED APPOINTMENTS ARE ASSESSED A FEE OF $100

Our practice is dedicated to quality care and exceptional service. We respect the importance of your time and work very hard to schedule appointments that accommodate the busy scheduling needs of all our patients. In return, we ask that patients make every effort not to change reserved dental appointments. When appointments are missed or little notice is given, other patients who need appointments have to wait. Also, missed or broken appointments interfere with your dental treatment. If an appointment needs to be changed we request one weeks notice. If one week's notice is not possible we require **2 BUSINESS DAYS**. A charge of $100 will be applied to broken or missed appointments without a 2 BUSINESS DAYS NOTICE. Thank you for your cooperation in this matter.

PAYMENT
As a patient, or legal guardian of a minor patient, I agree to pay for all services rendered in accordance with the terms and conditions set forth in the financial policy of the office, as stated above. Payment is due at the time of service. There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to Interest Charges of 0.75% per month on unpaid balances, which is an Annual Percentage Rate (APR) of 9%.

PAYMENT PLANS

Payment plans are available through CareCredit. CareCredit helps you pay for out-of-pocket healthcare expenses for you and your family. Once you are approved, you can use it to help manage health, wellness and beauty costs not covered by insurance. Please note that you must apply and be approved prior to your appointment to use this payment option.

I hereby authorize Thurston Family Dental to furnish my Insurance Company/Companies all information required concerning my dental care. I hereby assign to Thurston Family Dental, all payments to which I may be entitled for dental expenses, and do hereby direct that payment for such expenses be paid directly to Thurston Family Dental.

_____
Signature of Patient or Legal Guardian Date

_____
Patient Name

NOTICE OF PRIVACY PRACTICES

I have received a copy of this office's Notice of Privacy Practices

_____
Print Name

_____ _____
Signature Date

We may disclose your health information to a family member, personal representative, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. Please list the individuals who have your permission to share your health information:

Individual 1

Name: _____

Relationship to Patient: _____

Conditions of Access: _____

Individual 2

Name: _____

Relationship to Patient: _____

Conditions of Access: _____

Individual 3

Name: _____

Relationship to Patient: _____

Conditions of Access: _____

Individual 4

Name: _____

Relationship to Patient: _____

Conditions of Access: _____

_____ For office use only _____

We have attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communication barriers prohibited obtaining the acknowledgement
- An emergency situation Prevented us from obtaining acknowledgement
- Other (Please Specify) _____

Staff initials _____

Patient: _____ *Age:* _____ *Date:* _____

1. *I hereby authorize Dr. Daryl Fedak or Associate Dentist and /or such assistants as may be selected by him, to perform Routine Dental Care upon the above named and /or any other therapeutic procedure that his/her/ their judgment may dictate to be advisable for the patient's well-being.*
2. *The nature and purpose of the procedure and anesthetic, the risks involved, and the possibility of complications has been explained to me. I acknowledge that no guarantee or assurance has been made as to the results that may be obtained. The advantages and inherent risks of anesthesia and sedation have been explained to me and I authorize the administration of such anesthesia and sedation as may be considered necessary or desirable.*
3. *I authorize that any specimens, tissue or parts removed from the patient may be disposed of in accordance with established practice.*
4. *I further authorize the performance by any qualified person of any other services, which are deemed to be necessary or advisable.*
5. *If in Dr. Fedak or an Associate Dentist's opinion, further observation of the above named patient is indicated after delivery of an anesthetic or procedure, the above named agrees to be transported by ambulance at his/hei personal expense to a mutually satisfactory hospital in the local area to be admitted for observation and anv necessary treatment.*
6. *If in Dr. Fedak or Associate Dentist's opinion, the above named patient requires the services of a specialist, he/ she agrees to accept the referral and will be responsible for any expense that may be incurred.*
7. *I certify that I have read this Consent, or that it has been read to me, and I understand the above. The nature and purpose of such operation's, procedure's, treatment's, and/or services and the reasons why the same is (are) considered necessary or advisable have been explained to me.*

→ _____ _____

Signature of Patient *(or Person Authorized to Sign for Patient)*

_____

(Relationship to Patient)

CONTINUING CONSENT:

Procedure	*Initials*	*Date*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Physician's Name: _____ Phone: _____ Patient's Name: _____

Have you been treated for any of the following?

- AIDS/HIV ◯ Yes ◯ No
- Artificial Joints/Implants ◯ Yes ◯ No
  - If yes, please list part (knee/hip/breast):
  - Implant date: _____
- Premed required? ◯ Yes ◯ No
- Artificial Heart Valve ◯ Yes ◯ No
  - If yes, please list type/date: _____
- Back/Neck Injury ◯ Yes ◯ No
- Asthma ◯ Yes ◯ No
- Cancer ◯ Yes ◯ No
  - If yes, please list type/date: _____
- Chemical Dependency ◯ Yes ◯ No
- Chemotherapy/Radiation ◯ Yes ◯ No
- Diabetes ◯ Yes ◯ No
  - If yes, which one? 1 or II? _____
- Emphysema ◯ Yes ◯ No
- Epilepsy ◯ Yes ◯ No
- Fainting/Dizziness ◯ Yes ◯ No
- Headaches ◯ Yes ◯ No
- Heart Attack ◯ Yes ◯ No
  - If ves, when? _____
- Heart Disease ◯ Yes ◯ No
- Heart Murmur ◯ Yes ◯ No
- Heart Problems ◯ Yes ◯ No
- Hepatitis ◯ Yes ◯ No
  - If yes, which one? A B C? _____
- Tuberculosis ◯ Yes ◯ No
  - If yes, when? _____
- Hemophilia/Bleeding Disorder ◯ Yes ◯ No
- High Blood Pressure ◯ Yes ◯ No
- High Cholesterol ◯ Yes ◯ No
- Stroke ◯ Yes ◯ No
  - If yes, when? _____
- Kidney Disease ◯ Yes ◯ No
- Thyroid Problems ◯ Yes ◯ No
- Liver Disease ◯ Yes ◯ No
- Low Blood Pressure ◯ Yes ◯ No
- Mitral Valve Prolapse ◯ Yes ◯ No
- Scarlet Fever ◯ Yes ◯ No
- Psychiatric Care ◯ Yes ◯ No
- Arthritis, Rheumatism ◯ Yes ◯ No
- Blood Disease ◯ Yes ◯ No
- Others, Please List:
  - _____
  - _____
  - _____

Are you allergic to or had any reactions to the following:

- Local Anesthetics ◯ Yes ◯ No
- Penicillin ◯ Yes ◯ No
- Erythromycin ◯ Yes ◯ No
- Codeine ◯ Yes ◯ No
- Anti-inflammatory ◯ Yes ◯ No
- Acetaminophen ◯ Yes ◯ No
- Others, Please List:
  - _____
  - _____
  - _____

- Do you use Tobacco? ◯ Yes ◯ No
  - If yes, what type and how often? _____
- Do you use Marijuana? ◯ Yes ◯ No
  - If yes, how often?_____
- Do you have a defibrillator or pacemaker? ◯ Yes ◯ No
- Have you ever had prolong bleeding following an extraction? ◯ Yes ◯ No
- Are you currently taking any blood thinners? ◯ Yes ◯ No
- Are you currently or have you ever taken bisphosphonates? ◯ Yes ◯ No
- Do you have any sores or lumps in or near your mouth? ◯ Yes ◯ No
- Herpes/Cold Sore/Blister/Feve ◯ Yes ◯ No
- Do you clench or grind your teeth? ◯ Yes ◯ No
- Do your gums bleed while flossing? ◯ Yes ◯ No
- Do you wear dentures or partials? ◯ Yes ◯ No
  - If yes, please list date of initial placement: _____
- Are you interested in improving your smile with Teeth Whitening? ◯ Yes ◯ No
- Are you under any medical treatment now? ◯ Yes ◯ No
  - Medication:
    - _____ Treatment:
    - _____ _____
    - _____ _____
- Blood Pressure/Date Taken _____ _____ _____

Women:

- Are you pregnant? If yes, please list due date: _____ ◯ Yes ◯ No
- Are you taking any oral contraceptives? ◯ Yes ◯ No
- Are you nursing? ◯ Yes ◯ No

Please list the reason for your visit today: _____
Please list your long term dental goals: _____
What is the name of your previous dentist/location? _____

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. I authorize the dentist to release any information including the diagnosis and results of any treatment or examination rendered to me or my child during the period of such dental care to third party payers 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 billed amount for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or parent if minor) _____ Date:_____

Provider Signature _____ Date:_____