Broadway Heights Dental

broadwayheightsdental.com office@broadwayheightsdental.com
12120 E Broadway Ave - Spokane, WA 99206 (509) 926-8866

Patient Name: _____ _____ , _____ , _____ _____ , _____ _____
First MI Last Preferred Name

Medical History

Please indicate which of the following conditions you have or have had. By checking the box it will indicate a "YES" response. Leaving the box blank will indicate a "NO" response.

- ☐ Joint Replacement
- ☐ Premed
- ☐ Allergy – Penicillin
- ☐ Allergy – Clindamycin
- ☐ Allergy – Doxycycline/Minocycline
- ☐ Allergy – Aspirin/Ibuprofen
- ☐ Allergy/Adverse Reaction – Anesthetic
- ☐ Allergy – Other
- ☐ Osteoporosis
- ☐ Cancer
- ☐ Chemo
- ☐ Radiation
- ☐ FEMALE: Currently Pregnant
- ☐ FEMALE: Currently Nursing
- ☐ Diabetes
- ☐ Neurological/Developmental Condition
- ☐ Seizures/Epilepsy
- ☐ Dizziness/Fainting
- ☐ Alzheimer's
- ☐ Autoimmune Disease
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Cold Sores
- ☐ Sleep Apnea
- ☐ Snoring
- ☐ Tobacco/Nicotine Use

1. If any conditions or alerts selected above need further explanation, please describe below:

_____

_____

_____

2. Please list any medications (prescription and non-prescription):

_____

_____

_____

3. If you selected "Joint Replacement" above, have you been advised by your surgeon/physician to take an antibiotic/Premed prior to dental appointments? If so, please state the antibiotic recommended:

_____

4. If you selected "Osteoporosis" above, which medications (if any) have you taken? (Fosamax,Boniva,Prolia,etc)

_____

5. Please list any hospitalizations or surgeries in the past 3 years:

_____

_____

_____

6. Have you ever been told you have gum disease or have had a deep cleaning requiring anesthetic? YES___NO____

7. Please provide the name of your physician and phone number:

_____

8. Please provide the name, location, and phone number of your preferred pharmacy:

_____

Patient Signature: (or parent/guardian if minor) _____ Date: _____

BROADWAY HEIGHTS
DENTAL

Notice of Privacy Practices Acknowledgement

We keep a record of health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We do not disclose your record to others unless you direct us to do so or unless the law authorizes us to do so. You may see your record or get more information about it by contacting Jani Cotton, HIPAA Privacy office.

Our notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (Parent, Guardian, Power of Attorney)

BROADWAY HEIGHTS
DENTAL

Consent for Services and Financial Policy

As a condition of treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment. All emergency dental services performed without previous financial arrangements, must be paid for at the time services are performed unless other arrangements are made. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services under the assumption that our charges will be paid by the patient's insurance company. A service charge of 1.5% per month (18% annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied. I understand that any fee estimate for this dental care can only be extended for a period of six months from the date of the patient examination. In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services, at the time of treatment. I further agree that the charges for the services shall be as billed unless objected to, by me, in writing within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit bee instated hereunder. I grand my permission to you or your assignee, to telephone me to discuss this statement of my treatment.

▫ By checking this box, I understand the above information and agree with its consents, and this will serve as my electronic signature for the financial policy.

Cancellation Policy

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for your scheduled appointments to be cancelled at least 24 hours in advance. Our doctors and hygienists want to be available for your needs and the needs of all of our patients. When a patient does not show up for a scheduled appointment, another patient loses the opportunity to be seen. Although we have always had a cancellation policy, circumstances have caused us to enforce a policy of charging for no-show appointments, and those appointments who have not cancelled within 24 hours. There will be a $50.00 fee assessed if we do not receive a call to cancel an appointment. Thank you for being a valued patient and for your understanding and cooperation. This policy will enable us to open otherwise unused appointments to better serve the needs of all the patients.

▫ By checking this box, I understand the above information and agree with its consents, and this will serve as my electronic signature for the financial policy.

(509)926-8866 12120 E Broadway Ave Spokane Valley, WA 99212

BROADWAY HEIGHTS DENTAL

Authorization for release of dental records.

I authorize_____to release all of my dental records to Dr. Nathan Cotton D.M.D and Dr. Darrin Rich D.D.S.

Patient:_____Date of Birth_____

Please send:

Dental xrays, perio chart, and dates for any seated crowns to:

office@broadwayheightsdental.com

_____

Patient of legally authorized individual signature. **Date**

_____

Printed Name **Relationship to patient**

BROADWAY HEIGHTS
DENTAL

Reminder Preferences

Patient Name: _____ Date: _____

I give my consent to Broadway Heights Dental to remind me of future appointments in the following ways.

Please check all that apply and note that if the appointment is confirmed within one week of the appointment date, we will not continue to send reminders.

☐ EMAIL – Please send me email reminders of my appointments.

Your email: _____

☐ TEXTS – Please send me text reminders of my appointments.

☐ PHONE CALL – Please call me to remind me of my appointments. Voicemail? Y / N

The information may also be used to communicate with you regarding your treatment.

_____

Patient signature Date

BROADWAY HEIGHTS
DENTAL

Photograph Release

I hereby authorize Broadway Heights Dental and their staff to use photos taken of my teeth and smile. These pictures may be used for educational purposes for both staff and other patients. This photo may also be used on their website or social media platforms. I understand that my name will not be used.

Patient's Printed Name : _____

Patient's Signature : _____

Date Signed : _____