Dr. Dana A. Buglione DMD, MSD

3628 Meridian St. STE 1A
Bellingham, WA 98225

(360) 733-2303
frontdesk@bellinghamprosthodontics.com

PATIENT INFORMATION		DATE:	
❑Mr. ❑Mrs. ❑Ms. ❑Dr. First Name: M.I. Last Name:			
Sex: ❑Male ❑Female	Birth Date: / /	Age:	SSN:
Street Address:			
City:	State:		Zip Code:
Home Phone:		Cell Phone:	
E-mail Address:			
Have <u>you</u> ever been a patient in our practice? ❑ Yes ❑ No		Has a family member ever been a patient of our practice? ❑ Yes ❑ No	
Referred By:			
Primary Care Physician Name and Phone:			
Preferred Pharmacy Name and Phone:			
Emergency Contact:		Phone:	

Primary Insurance Information		
Insured Party First Name:		Last Name:
Birth Date: / /	SSN:	❑ Self ❑ Spouse Relationship:❑Other:
Employer:		
Business Address:		
Ins. Co. Name	I.D. #	Group Name/#:

Secondary Insurance Information		
Insured Party First Name:		Last Name:
Birth Date: / /	SSN:	❑ Self ❑ Spouse Relationship:❑Other:
Employer:		
Business Address:		
Ins. Co. Name	I.D. #	Group Name/#:

Guarantor Information:

(If someone other than the patient will be responsible for the account)

First Name:	Last Name:	
Birth Date: / /	SSN:	Relationship:
Street Address:		
City:	State:	Zip Code:
Ins. Co. Name	I.D. #	Group Name/#:

Dental Health History:

General Dentist:	Orthodontist:
Last Dental Visit:	Last Dental Cleaning:

Reason for Today's Visit:

Do you clench or grind your teeth? Has a dentist ever diagnosed you with bruxism? ❑Yes ❑No

Do you have a removable prosthesis? If so…

Complete Denture:	Partial Denture:
❑ Upper ❑ Lower	❑ Upper ❑ Lower
Year Made:	Year Made:

Do you take you dentures out for ~8 hours per day? ❑Yes ❑No

Are you satisfied with your current complete or partial dentures? ❑Yes ❑No

Are you satisfied with your smile? ❑Yes ❑No

What is your vision for your smile? What are your goals for dental treatment?

Health History:

General Health:❑Excellent ❑Good ❑Fair ❑Poor

Are you under the care of a physician? ❑Yes ❑No | Date of Last Physical:

What conditions are you being treated for? (List all)

❑❑

❑❑

❑❑

❑❑

❑❑

❑❑

❑❑

❑❑

In the last 5 years, have you had any of the following? ❑ Yes ❑ No

- Surgeries: _____
- Hospitalizations: _____
- Joint Replacement: _____
- Stents Placed: _____
- Other changes in your health:

Has a physician recommendedyou take antibiotics prior to dental treatment?❑ Yes ❑ No

Allergies? ❑ Yes ❑ No

❑ Antibiotics (including Penicillin)
❑ Local Anesthetic
❑ Seasons allergies
❑ Latex
❑ Opioids / Narcotics

Are you currently pregnant? ❑ Yes ❑ No Is there a possibility that you may be pregnant? ❑ Yes ❑ No

Current use of tobacco products?❑ Yes ❑ No Are you interested in quitting ❑ Yes ❑ Not at this time
Past use of tobacco products? ❑ Yes ❑ No
Type and how long?

Are you taking any **blood thinners**? ❑ Yes ❑ No
(Coumadin (warfarin), Plavix (clopidogrel), Eliquis (apixaban), Aspirin, Vitamin E, Gingko biloba, etc.)

Are you taking, or have taken **bone density meds**, RANKL inhibitors or bisphosphonates? ❑ Yes❑ No
(Denosumab, Fosamax, Boniva, Actonel, IV-Zometa, Aredia, Reclast, or Evista*in the past 12 years*?)

Is there anything else about your health that you feel is important?

Review of Systems: Do you have, or have had any of the following?	
❑Hypertension (high blood pressure)	❑ Asthma
❑Hypotension (low blood pressure)	❑ Emphysema
❑High Cholesterol	❑ Sleep Apnea
❑Chest Pain / Angina	❑ Trouble breathing / easily winded
❑Heart Murmur	❑ Tuberculosis
❑Arrythmia or irregular heart beats	❑ Lung Cancer
❑Atrial Fibrillation ("Afib")	❑ Pneumonia
❑Heart Valve issues or replacements	❑ Chronic Bronchitis
❑Heart Attack	❑ Chronic Sinusitis / sinus issues
❑ Stroke	❑ Arthritis
❑ Bleeding Problems	❑ Joint Problems / Surgeries
❑ Anemia	❑ Recent Skin Changes
❑ Pacemaker	❑ Osteoporosis
❑Memory Issues	❑ Contagious Disease
❑ Fainting	❑ Cold Sores
❑Tremors	❑ AIDS / HIV
❑ Parkinson's Disease	❑ Hepatitis A
❑ Epilepsy or seizures	❑ Hepatitis B
❑ Alzheimer's Disease	❑ Hepatitis C
❑ Dementia	❑ Hepatitis D or E
❑ Anxiety	❑ Liver Problems / Failure / Jaundice
❑ Depression	❑ Autoimmune Diseases
❑ Loss of interest in favorite activities	❑ Immune Issues
❑ Loss of interest in socializing	❑ Kidney Problems / Failure
❑ Psychiatric Care (schizophrenia, etc.)	❑ Kidney Dialysis
❑ Type 1 Diabetes Last A1C:	❑Hyperglycemia (high blood sugar)
❑ Type 2 Diabetes Last A1C:	❑ Hypoglycemia (low blood sugar)
❑ Excessive Thirst	❑ Hyperthyroid
❑ Delays in Healing from Meds / Surgery	❑ Hyporthyroid
❑ Osteonecrosis	❑ Parathyroid issues
❑ Sexually Transmitted Diseases	❑ Ulcers
❑ Leukemia	❑ Acid Reflux (GERD)
❑ Tumors or growths	❑ Radiation Therapy
❑ Eye Problems	❑ Chemotherapy

Medications, Herbals, Supplements			
Drug Name	Dosage	How often?	What are you taking it for?

FEES AND PAYMENTS

We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Payment is expected for services rendered that day, and prior to delivery for "crowns," "bridges," "dentures," and other prostheses. Other arrangements can be made with our office manager depending upon special circumstances. An estimate of the charge for any procedure you may require will be given to you upon request. If you have any dental and/or medical insurance we will be glad to fill out the proper forms, but please complete the identifying information on this form. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge Accounts due are payable as of date billed. An interest of 1.5% per month will be charged after 30 days. **It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.** You will be responsible for all collection costs, attorney's fees, and court costs.

X_____ X_____

Signature of patient *(Parent or Guardian if < 18)* **Date**

This signature on file is my authorization for the release of information necessary to process my claim.

Cancellation Policy

We require that you give us 48 hours' notice in the event that you need to reschedule your appointment. This allows for other patients to be scheduled into that appointment. If you miss an appointment without contacting our office with the required time, this is considered a missed appointment. A fee of $50.00 may be charged to you, the fee cannot be billed to your insurance and will be your responsibility. Additionally, being more than 20 minutes late without notice will be considered a missed appointment and you will be charged accordingly.

I have read and understand the cancelation policy, I agree to be bound by its terms. I also understand and agree such terms may be amended from time to time by the practice.

X_____ X_____

Signature of patient *(Parent or Guardian if < 18)* **Date**

PHOTOGRAPHIC RELEASE

We take intraoral (inside the mouth) and extraoral (outside of the mouth) photos of our patients. We do this for several reasons. First, it aids in record keeping and documentation. Photos will be taken of the condition in which you and your mouth presented to our office, giving a baseline of where you started. We will also take progress photos throughout your treatment, which aids in confirming tooth shade and color, fit of prostheses, etc. We also take photos after definitive treatment, both to show off your new smile, and to document it exactly as it was at the time of delivery. These photos are invaluable for assessing your dentition and your prostheses as your body ages and changes, as well as providing a legal record. They are an essential component of your medical record. Photos are also a very effective way to communicate with other dental specialists that may be involved in your care. Occasionally, photos are used in academic lectures for the purpose of teaching other dental professionals. Any photos that are used outside of your treatment needs with other dental professionals are deidentified (eyes are covered in full-face photos, or the photo is cropped to just show the mouth). By signing below, I understand that my photographs will be taken and used in the above manner. A request for a copy of these photos can be made at any time.

X_____ X_____

Signature of patient *(Parent or Guardian if < 18)* **Date**

I authorize my dentist and his / her designated staff, to perform an oral and maxillofacial examination, for the purpose of diagnosis and treatment planning. Furthermore, I authorize the taking of all x–rays required as a necessary part of this examination. In addition, if medically necessary, I authorize the release of any information acquired in the course of my examination and treatment to my other doctors and/or insurance carriers. I permit messages to be left on my phone and / or mobile phone concerning my appointment.

X_____ X_____

Signature of patient *(Parent or Guardian if < 18)* **Date**

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask **any questions I may have regarding this Notice.**

X_____**X**_____

Signature of patient *(Parent or Guardian if < 18)***Date**