Vista Dental
myvistadental.com
500 SE 192nd Ave Suite 300 • Vancouver, WA 98683

vistadental@comcast.net
(360)892-4519

Welcome to Vista Dental

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ ____________ ____ ____________
Last First MI Preferred Name

Title: ________
Mr/Ms/Mrs/etc

Gender: ◯ Male ◯ Female **Family Status:** ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: ____________ **SS#:** ___-__-____ **Prev. Visit:** ____________

Email Address: ______________________ **Best time to call:** ____________

Phone: ________ ________ ________ ____ ________ ________
Home Mobile Work Ext Fax Other

Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

How were you referred to our office?

____

____

Person to Contact in case of Emergency:

____

____

Emergency Contact Phone Number: ____________

Primary Dental Insurance

Name of Insured: ______________________ ______________________ ____
Last First MI

Insured's Birth Date: ____________ **ID #:** ____________ **Group #:** ____________

Insured's Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Insured's Employer Name: ______________________

Employer Address: ______________________ ______________________
Address 1 Address 2

______________________ ______ _____-____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Insurance Address: ______________________ ______________________

Address 1 Address 2

______________________ ________ ________

City State Zip Code

Secondary Insurance:

Name of Insured: ______________________ ______________________ ____

Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________________

Health History

What is your estimate of your overall health?

◯ Excellent ◯ Good ◯ Fair ◯ Poor

For Women

◯ Pregnant ◯ Nursing

Do you have any allergies?

☐ None ☐ Aspirin ☐ Ibuprofen ☐ Acetaminophen ☐ Codeine ☐ Penicillin
☐ Erythromycin ☐ Tetracycline ☐ Sulfa ☐ Dental Anesthetics ☐ Nuts ☐ Metals
☐ Latex ☐ Other (see below)

Other Allergies (not listed above):

____

____

Do you require a pre-medication prior to dental treatment due to a medical condition or joint replacement? (please list the medication *

____

____

Do you have or have ever had ◯ Yes ◯ No

☐ AIDS/HIV+ ☐ Alcohol Usage ☐ Allergies- Medicine ☐ Allergy - Food/Metal
☐ Anemia ☐ Arthritis ☐ Artificial Joints ☐ Asthma
☐ Blood Disease ☐ Blood Thinners ☐ Cancer ☐ Cold Sores
☐ Depression ☐ Diabetes ☐ Digestive Issues ☐ Endocarditis
☐ Ephysema ☐ Epilepsy ☐ Epinephrine Allergy ☐ Excessive Bleeding
☐ Fainting ☐ Fibromyalgia ☐ Gastric Reflux ☐ Head/Neck Injuries
☐ Heart Disease ☐ Heart Murmur ☐ Hepatitis ☐ High Blood Pressure
☐ High Cholesterol ☐ Hormone Deficiency ☐ Immunosuppressed ☐ Kidney Disease
☐ Liver Disease ☐ Lupus ☐ Marijuana Usage ☐ Mental Disorders
☐ MS ☐ Nervous Disorders ☐ Neurologic Disorders ☐ Osteoporosis
☐ Other ☐ PRE-MED ☐ Respiratory Problems ☐ Rheumatic Fever
☐ Sinus Problems ☐ Stent or Heart Valve ☐ Stomach Problems ☐ Street Drug Use
☐ Stroke ☐ Thyroid Issues ☐ Tobacco Use ☐ Tuberculosis
☐ Tumors ☐ Ulcers

Other Illnesses not listed:

____

____

Please list any medications you are currently taking:

____

____

Dental History

Personal History

Are you fearful of dental treatment or have you ever had unfavorable dental treatment? ◯ Yes ◯ No

Have you ever had complications associated with dental treatment? ◯ Yes ◯ No

Have you ever experienced trouble getting numb or had a reaction to anesthetics? ◯ Yes ◯ No

Have you ever had braces, orthodontic treatment or your bite adjusted? ◯ Yes ◯ No

Gum and Bone

Do your gums bleed or are they painful when brushing or flossing? ◯ Yes ◯ No

Have you ever been treated for gum disease, gum recession or dental bone loss? ◯ Yes ◯ No

Have you ever noticed an unpleasant taste, odor or burning sensation in your mouth? ◯ Yes ◯ No

Is there anyone with a history of periodontal disease in your family? ◯ Yes ◯ No

Do you have any difficulties biting into an apple? ◯ Yes ◯ No

Tooth Structure

Have you had any cavities in the past 3 years? ◯ Yes ◯ No

Does the amount of saliva in your mouth seem like too much or too little or do you have difficulty swallowing any food? ◯ Yes ◯ No

Do you avoid brushing any areas in your mouth? ◯ Yes ◯ No

Do you have any broken, chipped, cracked or painful teeth? ◯ Yes ◯ No

Do you frequently get food caught between any specific teeth? ◯ Yes ◯ No

Are your teeth sensitive to:

☐ Hot ☐ Cold ☐ Sweet ☐ pressure ☐ Other

Bite and Jaw Joint

Do you have any problems with your jaw joint? (pain, sounds, limited opening, locking, popping) ◯ Yes ◯ No

Do you avoid or have difficulty chewing gum, carrots, nuts or other hard, dry foods? ◯ Yes ◯ No

Have your teeth changed in the past 5 years, become thinner, shorter or worn? ◯ Yes ◯ No

Are your teeth crowding or developing spaces? ◯ Yes ◯ No

Do you chew ice, bite your nails, use your teeth to hold objects or have any other oral habits? ◯ Yes ◯ No

Do you clench your teeth during the day or grind your teeth at night? ◯ Yes ◯ No

Do you or have you ever worn a bite appliance or nightguard? ◯ Yes ◯ No

Smile Characteristics

Is there anything about the appearance of your teeth that you would like to change? ◯ Yes ◯ No

Have you ever whitened or bleached your teeth? ◯ Yes ◯ No

Have you ever felt uncomfortable or self-conscious about the appearance of your teeth? ◯ Yes ◯ No

Have you been disappointed with the appearance of previous dental work? ◯ Yes ◯ No

Signature

____

____

____

Response Date: ___/___/_____

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Financial Policy

Thank you for choosing Vista Dental! Our office purpose is to deliver the most exceptional comprehensive dental care available. An important part of our relationship with you, our patient, is making the cost of optimal dental care as easy as possible by offering payment options.

Payment Options Available:

Cash or personal check
A 5% courtesy discount is available to patients who pay for their treatment with cash or a personal check prior to the completion of care. Due to insurance regulations, discounts are not available if Vista Dental is billing your insurance.

American Express, Master Card, Discover Card, or Visa

Convenient Monthly Payment Plansi through Lending Club or Care Credit
6 - 24 months Deferred Interest for charges $200 and above
24, 36, and 48 month Budget Payment plans with low fixed interest for charges $1000 and above.

Vista Dental requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, your payment is non-refundable. For treatment plans requiring multiple appointments, alternative payment arrangements may be provided and will be discussed at the time treatment is being scheduled.

We are happy to work with you and your insurance company to help you maximize your benefits. By signing this financial policy you agree and authorize Vista Dental to bill your dental insurance for you. If your insurance does not pay what is estimated, the leftover balance is your responsibility. By signing below, you authorize your insurance company to assign benefits to this office so that we may credit them towards your account.

Parents not accompanying their child to an appointment must make prior arrangements for payment (cash, check or credit card authorization)

Because of we have reserved time exclusively for your dental appointment there is a $45 charge for patients who miss or cancel their appointments within a 24-hour period. For patients who have previously missed appointments or have had a cancellation history at Vista Dental, a pre-payment will be required to reserve future appointments. Vista Dental charges $30 for any returned personal check unpaid. Balance's over 60 days may result in interest fee's of 18%. If you have any questions, please do not hesitate to ask. We are here to help you obtain the dentistry you desire and it is our purpose at Vista Dental to provide you with a healthy mouth and a smile that will last you a lifetime!

If we do not receive payment from your specified insurance company within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance company,

Signing your name below serves as your aknowledgement that you understand and agree to the above information.

____

____

____

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HIPAA Privacy Policy

Notice of Privacy Practices

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you the Notice of Privacy Practices., our legal duties and your rights concerning your health information. We must follow the privacy practices that are described in this Notice and while it is in effect. This Notice takes effect December 1, 2008 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this notice

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment and healthcare operations.

For example:

-Treatment: We may use and disclose your health information to a physician, dentist or healthcare provider providing you treatment to you.
Payment: We may use and disclose health information to obtain payment for services we provide to you.
-Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations may include but are not limited to quality assessment, improvement activities, reviewing competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, education, accreditation, certification, licensing or credentialing activities.
-Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by you for authorization while it was in effect. All revocations must be signed in person.
-To Your Family and Friends: We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment of your healthcare.
-Persons Involved in Care: We may use or disclose your health information to a family member, your personal representative or a person responsible for your care in order to provide dental services.
-Marketing: We may send you via e-mail, phone, cell phone, text or mail, information regarding services or products that pertain to Dental Care. We may send you correspondence such as birthday cards, holiday cards or cards for special occasions. We may use photos of your teeth/lips for educational or marketing purposes. We may use your reviews or surveys for marketing.

Signing your name below serves as your aknowledgement that you understand and agree to the above information. *

___

___

___

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CONSENT TO SHARE DENTAL INFORMATION

Patient Name: ______________________________ Date of Birth: ______________

I HEARBY AUTHORIZE VISTA DENTAL TO SHARE: (Please check all that apply)

- ☐ Treatment plan information (such as treatment needs and details about oral health conditions)
- ☐ Medications I am taking
- ☐ Billing information
- ☐ Appointment Dates/Times and reasons for the visits

WITH THE FOLLOWING PEOPLE:

Full Name: ___________________________Relationship: _________________

Full Name: ___________________________Relationship: _________________

Full Name: ___________________________Relationship: _________________

☐ I do **not** want Vista Dental to share any of my health/dental information with anyone.

I understand that I may cancel this consent at any time, but that cancelling it will not affect any information that has already been released.

☐ I consent Vista Dental to leave detailed messages regarding my appointments, treatment needs and medications at the phone number/s listed below

Phone # ______________________________ Phone # ______________________________

Patient Signature: ________________________________ Date: ____________________