BIG COUNTRY FAMILY
Dental

First Name _____ **M.I.** ___ **Last Name** _____ **Date** _____

I Prefer To Be Called _____ **Email** _____

Address _____ _____ **City** _____ **State** ____ **ZIP** _____

Home Phone _____ **Cell Phone** _____ **Business Phone** _____

Date of Birth ___ /___/_____ **Gender** ☐Male ☐Female **Marital Status** _____

Referred By _____ **Social Security #** _____

Driver's License Number _____ **State** _____

EMERGENCY CONTACT

First Name _____ **Last Name** _____

Relationship To Patient _____

Home Phone _____ **Cell Phone** _____ **Business Phone** _____

RESPONSIBLE PARTY

Who Will Be Responsible For Your Account ☐Self ☐Spouse ☐Father ☐Mother ☐Other:

First Name _____ **M.I.** ___ **Last Name** _____

Address _____ **City** _____ **State** ____ **ZIP** _____

Home Phone _____ **Business Phone** _____ **Extension** _____

Date of Birth ___ /___ /_____ **Employer** _____

I hereby authorize the below named insurance company or companies to release payment directly to Big Country Family Dental or Robert Moon, D.M.D.. I understand that I am financially responsible whether or not paid by insurance.

Signature _____ Date ___ / ___ / ___

PRIMARY INSURANCE

Insurance Company Name _____ **Company Phone** _____

Company Address _____ **City** _____ **State** ____ **ZIP** _____

Group # _____ **Member ID#** _____ **SSN** _____

Insured's Name _____ **Relationship To Patient** _____

Insured's Date of Birth ___ / ___ /_____ **Insured's Employer** _____

Insured's Employer Address _____

SECONDARY INSURANCE

Insurance Company Name _____ **Company Phone** _____

Company Address _____ **City** _____ **State** ____ **ZIP** _____

Group # _____ **Member ID#** _____ **SSN** _____

Insured's Name _____ **Relationship To Patient** _____

Insured's Date of Birth ____/____/_____ **Insured's Employer** _____

Insured's Employer Address _____

BIG COUNTRY FAMILY Dental

HEALTH HISTORY

DATE: _____

Patient's Name: _____ *Birth Date:* _____

I. CIRCLE APPROPRIATE ANSWER (YES or NO) for the FOLLOWING QUESTIONS:

Yes No Have you been hospitalized or had a serious illness in the last three years?
If YES, describe: _____

Yes No Are you currently being treated by a physician? Why? _____

Date of your last medical exam? _____ **Preferred Pharmacy** _____

II. DO YOU HAVE OR HAVE YOU EVER HAD:

Yes No	Heart disease or heart attack	Yes	No	Chest pain (angina)
Yes No	Heart murmur or heart defect	Yes	No	Prosthetic heart valve
Yes No	Rheumatic fever or Scarlet fever	Yes	No	Stroke
Yes No	High blood pressure	Yes	No	Pacemaker
Yes No	Persistent cough or coughing up blood	Yes	No	Asthma
Yes No	TB, emphysema or other lung disease	Yes	No	Dry mouth
Yes No	Dizziness or fainting spells	Yes	No	Seizures
Yes No	Bleeding problems or bruise easily	Yes	No	AIDS
Yes No	**Artificial joint replacement**	Yes	No	**Tumors or cancer**
Yes No	Arthritis or rheumatism	Yes	No	Herpes or cold sores
Yes No	Hepatitis *type:* A B C	Yes	No	Anemia
Yes No	Parkinson's or Alzheimer's	Yes	No	Diabetes
Yes No	**Osteoporosis** or osteopenia	Yes	No	Sinus problems
Yes No	Depression or psychiatric care	Yes	No	Frequent headaches
Yes No	**Radiation therapy or chemotherapy**	Yes	No	Migraine headaches
Yes No	Family history of diabetes, heart problems, tumors	Yes	No	Other liver disease

III. ARE YOU TAKING OR DO YOU USE:

Yes No	Tobacco in any form	Yes	No	Aspirin or **blood thinners**
Yes No	Medication for weak bones			

LIST prescription medications you take: _____

LIST over-the-counter or natural products you take: _____

IV. WHAT ALLERGIES DO YOU HAVE?

Yes No	Antibiotics (Penicillin, Erythromycin, Sulfa, etc.)	Yes	No	Codeine or Morphine
Yes No	Barbiturates	Yes	No	Metals
Yes No	Latex	Yes	No	Anesthetics

Other: _____

V. WOMEN ONLY:

		Yes	No	Are you breast-feeding?
Yes No	Do you take birth control medication?	Yes	No	Are you pregnant?

VI. ALL PATIENTS:

Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form?
If so, please describe: _____

VII. WHAT IS MOST IMPORTANT TO YOU ABOUT YOUR DENTAL TREATMENT? (prioritize from 1 to 5 with 1 being *most* important)

_____ COMFORT _____ APPEARANCE _____ TIME _____ LONG -TERM CARE _____ IMMEDIATE EMERGENCY CARE

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any changes in my health history and/or medications.

X Patient's signature: _____ Date: _____

Change? **RECALL REVIEW** (if changes, see the back of form)

Yes No Patient's signature: _____ Date: _____

Yes No Patient's signature: _____ Date: _____

Yes No Patient's signature: _____ Date: _____

Big Country Family Dental

307 W. First Avenue Suite 1, Ellensburg, WA 98926
509.962.6172

Written Financial Policy

An important part of our commitment at Big Country Family Dental is to offer several financial options to make the cost of optimal care as easy and manageable as possible. If you have any questions, please do not hesitate to discuss your treatment plan, fees or financial arrangements with us.

Please initial each box to indicate that you have read the policy, understand it, and agree to its terms. Details may be found on the back of this form.

☐ I understand my **Payment Options are**:

- Cash, Check, Visa, or MasterCard
- Convenient Monthly Payment Plans[1] from CareCredit®
- Payment is expected at the time of my appointment.
- Big Country Family Dental charges $30 for returned checks

☐ I understand that my estimated **Dental Insurance Benefit** co-payment is due at the time of my treatment; and I agree that I am responsible for payment of any amount not reimbursed by my dental insurance carrier within 60 days.

☐ I understand the **Appointment Policy** as follows: My appointment is time reserved specifically for me.

- If I arrive more than 10 minutes late, my appointment may need to be rescheduled.
- If I miss or cancel an appointment without two (2) business days' notice, I may be charged a fee ranging from$ 89.00 up to the value of services scheduled for the missed appointment.

The **best** way to contact me day or night is:

☐ Text message Cell Phone #_____

☐ Email message Email address _____

☐ Direct phone contact Phone # _____

(With either text or email communication, we need confirmation that you received our message and have agreed to the appointment time. This can be as simple as a "Yes" reply.)

I have read the above information, understand it, and agree to its terms.

_____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)

[1] *Subject to credit approval*

Payment Details: For your convenience, we accept cash, personal checks, Visa, & MasterCard. There is a $30 charge for all returned checks. We have also partnered with CareCredit®, a trusted name in third-party healthcare financing. This company offers low-interest financing for qualified applicants. Ask us for a brochure or go to CareCredit.com for more information. By prioritizing treatment, those patients without dental insurance or on a tight budget can still complete their dental work by spreading appointments over several months or years.

Dental Benefit Details: Our goal is to make understanding your dental benefits as easy and stress-free as possible. Dental benefits are contracts between you or your employer and the insurance company. If you have any questions regarding your dental benefits, please contact your employer or insurance company directly. **While we do our utmost to obtain accurate insurance benefit information from your insurance carrier, this information is NOT binding, and we cannot be held liable for inaccurate estimations of benefits.** Ultimately, it is your responsibility to know your coverage. Our team members are pleased to discuss your financial options and submit your dental benefit claim forms to allow you to maximize your dental benefits.

Appointment Policy: Our goal is to reserve a time that works best for you while at the same time efficiently serving all of our other patients who have made a commitment to outstanding oral health. We strive to be flexible when schedule changes occur. We offer text messaging and email reminders in addition to, or in place of, phone call reminders. Postcard reminders are mailed prior to re-care (cleaning) visits. If you do not receive a confirmation reminder prior to your appointment, please call us to confirm it, as your contact information may have changed or we were unable to contact you. We are committed to exceptional communication regarding your dental visits and will customize a system that is best suited for you.

BIG COUNTRY FAMILY
Dental

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Big Country Family Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Big Country Family Dental reserves the right to change the privacy practices currently described in the statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ **Date:** _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:** _____
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

STOP-BANG Sleep Apnea Questionnaire

S (snore)	Do you SNORE?	Yes	No
T (tired)	Do you often feel TIRED or sleepy during the daytime?	Yes	No
O (observed)	Has anyone OBSERVED you stop breathing during your sleep (even	Yes	No
P (pressure)	Do you have or are you being treated for high blood PRESSURE?	Yes	No

B (bmi)	Is your Body Mass Index (BMI) more than 35?	Yes	No
A (age)	Is your AGE over 50 years old?	Yes	No
N (neck)	Is your NECK circumference 16 inches or greater?	Yes	No
G (gender)	Is your GENDER male?	Yes	No

The more Yes's you have the more likely you are to have obstructive sleep apnea. Speak with your healthcare provider about your results.

Adapted from:
STOP questionnaire: a tool to screen patients for obstructive sleep apnea. Chung F, Yegneswaran B, Liao P, Chung SA, Vairavanathan S, Islam S, Khajehdehi A, Shapiro CM. Anesthesiology. 2008 May; 108(5): 812-21.

High STOP-Bang score indicates a high probability of obstructive sleep apnoea. Chung F, Subramanyam R, Liao P, Sasaki E, Shapiro C, and Sun Y. Br J Anaesth. 2012 May; 108(5): 768–775.