Advanced AD Dentistry
at Century Square

Andreea Larhs, DDS, PS

Personal Information

Full Name:_____ I prefer to be called:_____

Home Address:_____CITY_____STATE_____ZIP_____

Mailing Address:_____CITY_____STATE_____ZIP_____

SSN:_____ DOB:_____ Drivers License#/State Issued:_____ ❒Male ❒ Female

Home Phone: _____ Cell Phone: _____ Work Phone: _____ Email: _____

Where would you like to be contacted for appointment reminders? Please check: Home ❒ Work ❒ Cell ❒ Email ❒

Employer:_____ Occupation:_____

Employer:_____Address:_____

Relationship Status: Married ❒ Single ❒ Domestic Partner ❒ Widowed ❒

Spouse/Partner's Name: _____DOB:_____

Spouses Employer: _____

Emergency Contact NOT living with you:_____ Phone #:_____

Who may we thank for referring you? ❒ Coworker/Friend :_____ ❒ Google ❒ Review Site_____

❒ Referring Doctor/Clinic (Name) _____ ❒ Work in Building ❒Insurance PPO ❒ Other _____

Primary Insurance Information

Do you have an FSA or HSA? _____

Name of Insured:_____ SSN:_____ DOB:_____

Employer:_____ Member ID: _____ Group #_____

Insurance Co._____ Address: _____

Insurance Co. Phone #:_____ City:_____ STATE_____ ZIP:_____

Secondary Insurance Information (if applicable)

Name of Insured:_____ SSN: _____ DOB:_____

Employer:_____ Member ID: _____ Group #_____

Insurance Co._____ Address:_____

Insurance Co. Phone #:_____ City:_____STATE_____ZIP:_____

Andreea Larhs, DDS, PS

Date of most recent Exam: _____Date of most recent x-rays: _____Date of most recent treatment:_____

What is your immediate concern: _____

Oral Health History (please answer all of the following)	YES	NO
1. Are you fearful of dental treatment? How fearful? (on a scale 1-10)_____	Yes ❒	No ❒
2. Have you ever had unfavorable dental experience? _____	Yes ❒	No ❒
3. Have you ever had complications from past treatment? _____	Yes ❒	No ❒
4. Have you ever had any trouble with being numb or any reactions to local anesthetic? _____	Yes ❒	No ❒
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	Yes ❒	No ❒
6. Have you ever had any teeth removed or missing teeth that never developed? _____	Yes ❒	No ❒
7. Do your gums bleed or are they painful when brushing or flossing? _____	Yes ❒	No ❒
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	Yes ❒	No ❒
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	Yes ❒	No ❒
10. Is there anyone with a history of periodontal disease in your family? _____	Yes ❒	No ❒
11. Have you ever experienced gum recession? _____	Yes ❒	No ❒
12. Have you ever had any teeth become loose on their own (without injury)? _____	Yes ❒	No ❒
13. Have you experienced burning or painful sensation in your mouth not related to your teeth? _____	Yes ❒	No ❒
14. Have you had any cavities within the past 3 years? _____	Yes ❒	No ❒
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing food? _____	Yes ❒	No ❒
16. Do you feel or notice any holes (pitting or craters) on the biting surface of your teeth? _____	Yes ❒	No ❒
17. Do you have sensitivity to hot, cold, sweets, biting or do you avoid brushing any part of your mouth?_____	Yes ❒	No ❒
18. Do you have grooves or notches on your teeth near the gum line? _____	Yes ❒	No ❒
19. Have you ever broken teeth, chipped teeth or had a toothache or cracked filling? _____	Yes ❒	No ❒
20. Do you frequently get food caught between any teeth? _____	Yes ❒	No ❒
21. Do you have problems with your jaw joint? (pain, sounds, issues with opening/closing)_____	Yes ❒	No ❒
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	Yes ❒	No ❒
23. Do you avoid or have difficulty chewing hard or chewy food? (i.e., gum, bagel, nuts, etc) _____	Yes ❒	No ❒
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	Yes ❒	No ❒
25. Are your teeth becoming more crooked crowded or overlapped? _____	Yes ❒	No ❒
26. Are your teeth developing spaces or becoming loose? _____	Yes ❒	No ❒
27. Do you have more than one bite, squeeze or shift your jaw to make your teeth fit together? _____	Yes ❒	No ❒
28. Do you place your tongue between your teeth or close your teeth against your tongue? _____	Yes ❒	No ❒
29. Do you have any oral habits (i.e. chew ice, bite nails/pen caps, etc.)? _____	Yes ❒	No ❒
30. Do you clench your teeth in the daytime or make them sore? _____	Yes ❒	No ❒
31. Do you have any problems with sleep or restlessness, wake up with headaches or awareness of teeth? ____	Yes ❒	No ❒
32. Do you wear or have you ever worn a bite appliance? _____	Yes ❒	No ❒
33. Is there anything about the appearance of your teeth that you would like to change? _____	Yes ❒	No ❒
34. Have you ever whitened (bleached) your teeth? _____	Yes ❒	No ❒
35. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	Yes ❒	No ❒
36. Have you been disappointed with the appearance of previous dental work? _____	Yes ❒	No ❒
37. Are you interested in learning more about: Veneers ❒ Implants ❒ Botox for TMJ ❒ Botox/Dermal fillers ❒ Invisalign ❒ Other ❒		

Advanced AD Dentistry
at Century Square

PLEASE READ

Responsibilities and Release:

I understand that I am financially responsible for all charges whether paid by insurance or not. I authorize the doctor to release all information necessary to secure payment of benefits. I authorize and request my insurance company to pay directly to the dentist the insurance benefits otherwise payable to me. I authorize the use of my signature below on all insurance submissions. I understand that my dental insurance may pay less than the actual bill of services.

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

Office Guidelines:

- As a courtesy to you, we will bill your insurance; however this is NOT a guarantee of insurance payment. Payment of dental services not covered or paid by your insurance is required at the time services are provided.
- For your convenience financing may be obtained for full and/or partial treatment through CareCredit, a third party financing company. We can help you with the application process.
- **YOUR APPOINTMENT IS SPECIFICALLY RESERVED FOR YOU.** A fee of $**60.00 PER HOUR** will be charged to and paid by the patient for any appointment that is cancelled without at least two business days notice.
- A 1.5% per month (18% annually) finance charge may be added to any account with a past due balance of 90 days starting from the date services are rendered.
- We do not accept DSHS, Medicare or Medicaid.
- Nitrous oxide is available at $52.00 per hour. Payment is due at the time of service. This is rarely covered benefit on any insurance plan and will be billed and collected at time of service.
- Parking validation for your dental appointment is available at the 3rd and Stewart garage only.

I have read and understand the above stated guidelines and services.

Responsible Party Signature: _____ Date: _____

Relationship to Patient: _____

Advanced AD Dentistry
at Century Square

Patient Health History

Patient Name:_____ Date: _____

MEDICAL Doctor Name._____ Phone #:_____ Date of last visit: _____

*Do you have or have had any of the following conditions listed below – **Please check all that apply***

- ❒ Diabetes (HbA1C = _____)
- ❒ Thyroid problems
- ❒ Autoimmune disorder
- ❒ Hormone deficiency
- ❒ Shortness of breath
- ❒ Asthma
- ❒ COPD (emphysema, bronchitis)
- ❒ TB
- ❒ Stroke
- ❒ Heart Murmur
- ❒ Rheumatic or Scarlet Fever
- ❒ High blood pressure _____
- ❒ Angina/chest pain
- ❒ Pacemaker/ defibrillator
- ❒ Heart attack
- ❒ History of infectious endocarditis
- ❒ Artificial heart valve, repaired heart defect
- ❒ High cholesterol
- ❒ Other heart/circulatory problems
- ❒ Bleeding disorder/abnormal bleeding
- ❒ Renal/kidney problems/dialysis
- ❒ Gastrointestinal problems/ulcers/reflux
- ❒ Liver problems/ jaundice
- ❒ Hepatitis – Type: _____
- ❒ Skin rash, hives, hay fever
- ❒ Joint replacement
- ❒ Muscle/bone problems
- ❒ Osteoporosis/osteopenia
- ❒ Bisphosphanate use which one:_____
- ❒ Headaches
- ❒ Jaw pain
- ❒ Neurologic/neuromuscular disorder
- ❒ Epilepsy/seizures
- ❒ Psychiatric treatment
- ❒ STD: _____
- ❒ HIV/AIDS
- ❒ Viral infection, cold sores
- ❒ Any lumps or swelling in the mouth
- ❒ Eye conditions, glaucoma
- ❒ Sleep apnea, snoring
- ❒ Sinus problems
- ❒ Trauma, head or neck injuries: _____
- ❒ Smoking – how much:_____
- ❒ Alcohol abuse
- ❒ Recreational drugs – type:_____

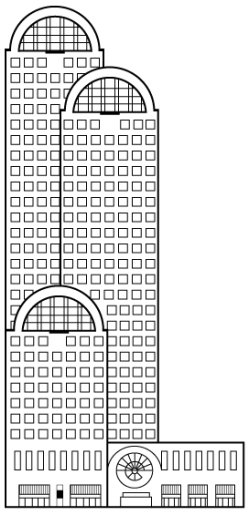
Are you pregnant? ❒ Yes - due date:_____ ❒ No

Are you nursing? ❒ Yes ❒ No

Describe below any medical treatment, impending surgeries, genetic/development delay, or other treatment that may affect your dental treatment (e.g. Botox, collagen injections) _____

MEDICATION	ALLERGIES	SURGERIES/HOSPITALIZATIONS

Advanced AD Dentistry
at Century Square



Advanced Dentistry
at Century Square

Andreea Larhs, DDS, PS
www.drlarhs.com

1501 4th Avenue, Suite 312
Seattle, WA 98101

Tel 206-292-9900
Fax 206-233-2724

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Additional Disclosure Authority:

May we discuss your treatment with:

Entire family	☐ Yes	☐ No
Spouse only	☐ Yes	☐ No
Others (specify)	☐ Yes	☐ No

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

☐ The patient refused to sign ☐ Emergency situation

☐ Communication barriers ☐ Other