MICHELLE METCALF
CONTEMPORARY DENTISTRY

Patient Information **Date**______________

Name:____________________I Prefer to be called: ____________
Address:____________________City:__________State:________Zip:__________
Phone (______)______________Work Phone (_____)______________Cell Phone (______)______________
The best time to contact me is:____________ ☐ A.M. ☐ P.M. on my ☐ Home phone ☐ Work phone ☐ Cell phone
Date of Birth:__________Social Security Number:____________Occupation:____________
Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
If Student, Name of School:______________City/State:______________ ☐ FT ☐ PT
Spouse's Name:______________Physicians Name:____________Phone____________
Whom may we thank for referring you? ______________________
Person to contact in case of emergency:__________________Phone:____________
Email Address:______________________
Would you like to receive text message appointment confirmations from our office? ☐ Yes ☐ No

Responsible Party

Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Other
Name:______________________Social Security #: ____________
Address:______________________________
City:______________State:________Zip:__________Phone: (_____)______________
Employer:______________Work Phone: (_____)______________Address:______________

Insurance Information

Name of Insured:______________DOB:__________Relationship to Patient: __________
SSN#:____________Name of Employer:____________Work Phone: (_____)__________
Address of Employer:______________City:__________State:________Zip:________
Insurance Company:______________Grp #____________ID#____________
Ins Co Address:______________________Ins Co. Phone:______________

------------ DO YOU HAVE ANY ADDIONAL INSURANCE? ☐ Yes ☐ No IF YES, COMPLETE THE FOLLOWING ------------

Name of Insured:______________DOB:__________Relationship to Patient:__________
SSN#:____________Name of Employer:____________Work Phone: (_____)__________
Address of Employer:______________City:__________State:________Zip:________
Insurance Company:______________Grp #____________ID#____________
Ins Co Address:______________________Ins Co. Phone:______________

Signature:______________________________Date:______________________

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PATIENT NAME ____ **DATE** ______________

MEDICAL HISTORY

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯Yes ◯No If yes, please explain:________________
Have you ever been hospitalized or had a major operation? ◯Yes ◯No If yes, please explain:________________
Have you ever had a serious head or neck injury? ◯Yes ◯No If yes, please explain:________________
Are you taking any medications, pills, or drugs? ◯Yes ◯No If yes, please explain:________________
Do you take, or have you taken, Phen-Fen or Redux? ◯Yes ◯No If yes, please explain:________________
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯Yes ◯No If yes, please explain:________________
Are you on a special diet? ◯Yes ◯No If yes, please explain:________________
Do you use tobacco? ◯Yes ◯No If yes, please explain:________________
Do you use controlled substances? ◯Yes ◯No If yes, please explain:________________

WOMEN *Are You*

Pregnant/Trying to get pregnant? ◯Yes ◯No Taking oral contraceptives? ◯Yes ◯No Nursing? ◯Yes ◯No

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

◯Aspirin ◯Penicillin ◯Codeine ◯Acrylic ◯Metal ◯Latex ◯Local Anesthetics ◯Sulfa Drugs ◯Other If Yes, please explain________________

DO YOU HAVE, OR HAVE YOU HAD ANY OF THE FOLLOWING?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes-Last A1C____	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Family history of diabetes	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Drug Addiction/Alcoholism	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Breathing Problem	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Stomach/Intestinal Disease	Yes	No
Bruise Easily	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Glaucoma	Yes	No	Marijuana Use	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Heart Pace Maker	Yes	No	Parathyroid Disease	Yes	No	Yellow Jaundice	Yes	No
			Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No			
			Family history of heart disease	Yes	No						

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain:________________

DENTAL HISTORY

Are you aware of any particular dental problems currently? ◯ Yes ◯ No If yes, explain: ________________
Have you had any serious trouble associated with any previous dental treatment? ◯ Yes ◯ No If yes, explain: ________________
Do you ever have bleeding gums? ◯ Yes ◯ No
Have you ever been treated for periodontal disease (Pyorrhea)? ◯ Yes ◯ No Have any family members? ◯Yes ◯No
Have you ever had any adult teeth extracted in the past? ◯ Yes ◯ No If yes, did you have any healing problems or prolonged bleeding? ◯Yes ◯No
Do you clench or grind your teeth, as far as you know? ◯ Yes ◯ No
Do you have any pain in or near your ears? ◯ Yes ◯ No
Do you hear clicking, popping or snapping noises when you chew? ◯ Yes ◯ No
Do you have sensitive or sore teeth? ◯ Yes ◯ No
Do you have any unhealed injuries or inflamed areas in or around your mouth? ◯ Yes ◯ No
Have you experienced any growth or sore spots in your mouth? ◯ Yes ◯ No
Approximate date of last dental appointment? Date:______________ Reason:________________
Have you ever had instructions on the correct method of brushing and flossing your teeth? ◯ Yes ◯ No
How would you rate your level of dental anxiety? None Slight Moderate Severe
If there was one thing you could do to improve your smile, would you? ◯ Yes ◯ No What would it be? ________________
Would you like to straighten your teeth? ◯ Yes ◯ No
Are you interested in having whiter teeth? ◯ Yes ◯ No
Are you involved in any sports activity? ◯ Yes ◯ No

Staff Signature:________________________________ Date:________________________

MICHELLE METCALF
CONTEMPORARY DENTISTRY

FINANCIAL AGREEMENT

"Our commitment is to provide the highest level of dental care for the entire family through exceptional service"

METHODS OF PAYMENT

1. Cash, Check, Debit, or Credit Card (Visa, MasterCard, Discover and American Express)
2. Dental Insurance
3. Outside Financing (Approved prior to treatment)

FINANCIAL POLICY

1. Payment for services rendered is due at time of treatment.

2. As a courtesy, we will file your insurance and accept assignment as authorized. Your deductible and estimated co-payment will be collected at time of service. For patients with multiple insurance plans, we ask a credit card number be kept securely on file to cover any balances left after 60 days. A statement will be sent showing any credit card activity.

3. We would be pleased to assist you in interpreting your dental benefits. Due to plan limitations, as determined by your employer or yourself, please understand that our interpretation is not guarantee of coverage.

RELATED INFORMATION

1. Your appointment time has been reserved exclusively for you. Any short notice changes to your appointment block effects many patients. Absolutely no fee will apply to changes in schedule made 48 hours in advance. A $50 fee will be charged for scheduling changes made with less 48 hours notice.

2. Failing to comply with the financial policies will result in applicable service charges and possible delays in your treatment.

3. In the event that the account is not paid and we refer the account to a Credit Bureau, you will be responsible for all fees incurred for collection of you bill (i.e. attorney fees, court costs, and credit bureau fees).

I have read and understand the above information. I understand I am responsible (regardless of my insurance) for any charges incurred for services rendered.

Patient Name ____

Name of Responsible Party if under 18 ____

Relationship to patient _______________

Signature: ____Today's Date: __________

Dr. Michelle Metcalf • 2829 South Grand Blvd. Suite 301 • Spokane, WA 99203 • 509.747.4242

MICHELLE METCALF
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WARRANTY

Our practice is proud of the dentistry that we provide for you and your family. Our goal is not only to correct any dental problems you may have, but also to show you how to prevent dental disease in the future to save you time and unnecessary expense. The long-term success of the dental treatment we provide for you depends upon the continuing home care of your teeth and gums, regular professional exams, cleanings and fluoride treatments. The products recommended by us for you, and the frequency of your oral health care visits depend on your individual condition. These visits may be every 2, 3, 4 or even 6 months apart depending on your oral health. With that in mind, we offer the following limited dental warranties:

Composite Fillings (Tooth Colored)

If a composite restoration is the recommended treatment of choice, we will replace or repair it in the event of material failure for a period of 2 years. If the tooth breaks and requires a crown or onlay during this time period, we will credit the cost of the filling toward the crown or onlay.
You must keep the prescribed regular oral health care visits or this warranty is null and void. (Minimum every 6 months)

Dental Sealants

Sealants are plastic coatings placed on the chewing surfaces of the teeth to prevent decay in the pits and grooves of the teeth. These are the most common areas to get cavities. Floss and the use of fluoride will help prevent decay between teeth. We will repair or replace sealants for a period of 3 years after placement.
You must keep the prescribed regular oral health care visits or this warranty is null and void. (Minimum every 6 months)

Crowns, Bridges, Inlays, Onlays and Veneers

We provide a 5 year warranty on these procedures. We will replace or repair them at no charge during this five year period if the materials fail. (This does not include accidents that could break normal healthy teeth).
You must keep the prescribed regular oral health care visits or this warranty is null and void. (Minimum every 6 months)

Note: As you can see, we are confident in the durability of our treatment as prescribed for you. The primary key to your long term success is spending a few minutes a day on your home care: brushing, flossing, using fluoride and prescribed products. The second key to success is regular professional exams, cleanings, x-rays and fluoride treatments (2,3,4 or 6 month intervals depending on your condition). This warranty does not cover accidents that cause damage to the teeth or dental prostheses. Failure to have these regular visits with our office voids all warranties. Allow us to help you maintain your teeth for a lifetime.

Patient name: ____

Name of Responsible Party if under 18: ______________________________

Signature: ____ Date:__________

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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 Jodi W. Funk, DDS. 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.

Jodi W. Funk, DDS reserves the right to change the privacy practices that are 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 to me.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family ◯ YES ◯ NO

Spouse only ◯ YES ◯ NO

Other (Please Specify): ◯ YES ◯ NO

PRINT Name of Patient or Personal Representative

SIGN Name of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Office Use Only Below This Line

Provided prior to treatment? YES NO

Date provided:

Reason for denial: Needed more time to review statement of privacy practices.

Wanted to consult with another person, before signing.

Unable to sign. Reason not given.

Other (Explain):

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Record Release Agreement

I authorize Dr. Michelle Metcalf to release diagnosis & treatment information to physicians, other dentists, and to my insurance company. I also authorize Dr. Michelle Metcalf to request diagnosis & treatment information from physicians, other dentists, and my insurance company. I understand that I may revoke this authorization in writing; however, doing so would not affect any actions already taken by Dr. Metcalf’s office based on this authorization.

Patient name: ____

Name of Responsible Party if under 18 ___________________________________

Relationship to patient _____________

Signature : _________________________________ Date:_________

SMILE ANALYSIS

Patient Name: ____ Date: _____________

Rate your smile from 1-10. ______

What would make it a 10?

When I see a picture of myself, the first thing I notice about my smile is:

Something I often notice about other smiles I consider attractive is:

Aside from yourself, who is the most important person you would want to like your new smile?

Please check the boxes next to the statements below that you agree with:

- ☐ I am satisfied and happy with my smile as it is.
- ☐ I wish my teeth were whiter.
- ☐ I wish I had a broader smile.
- ☐ I think some of my teeth are too small.
- ☐ I think some of my teeth are too large.
- ☐ I wish my teeth were straighter.
- ☐ I think my gums show too much when I smile.
- ☐ I think my smile shows too much space between some of my teeth.
- ☐ Because I am not totally pleased with my smile, I sometimes hesitate to smile.
- ☐ I have often wished I could change some of the features of my smile.
- ☐ I feel as though I don't really know all of the options available for enhancing my smile.
- ☐ Concerns over fees have prevented me from taking advantage of some of the available options to enhance my smile.
- ☐ I feel as though I could do a better job protecting the health of my teeth and gums and therefore, the longevity of my own smile.