Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

NEW PATIENT FORM

Basic Information

Name:		Gender:	
Preferred Name:		DOB:	
SSN #:		Marital status:	
Referral source:		Employer:	
Referred by:		Occupation:	

Contact Information

Mobile phone:	
Home phone:	
Email:	

Address Information

Street address:	
City:	
State:	
ZIP:	

Emergency Contact

Full Name:	
Phone number:	
Relation:	

Work Information

Street address:	
City:	
State:	
ZIP:	

Patient's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

PRIVACY POLICY CONSENT

CLIENT RIGHTS AND HIPAA AUTHORIZATIONS

The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time (HIPAA).

1. Tell your provider if you do not understand this authorization, and the provider will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to the provider at the following address: 19214 Bothell Way NE, Ste. B Bothell, WA 98011:

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, payment, enrollment or your eligibility for benefits. However, you may be required to complete this authorization form before receiving treatment if you have authorized your provider to disclose information about you to a third party. If you refuse to sign this authorization, and you have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a patient in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA. If the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

5. You may inspect or copy the protected dental information to be used or disclosed under this authorization. You do not have the right of access to the following protected dental information: psychotherapy notes, information compiled for legal proceedings, laboratory results to which the Clinical Laboratory Improvement Act (CLIA) prohibits access or information held by certain research laboratories. In addition, our provider may deny access if the provider reasonably believes access could cause harm to you or another individual. If access is denied, you may request to have a licensed health care professional for a second opinion at your expense.

6. If this office initiated this authorization, you must receive a copy of the signed authorization.

7. You have a right to an accounting of the disclosures of your protected dental information by the provider or its business associates. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The provider is not required to provide an accounting for disclosures: (a) for treatment, payment, or dental care operations; (b) to you or your personal representative; (c) for notification of or to persons involved in an individuals dental care or payment for dental care, for disaster relief, or for facility directories; (d) pursuant to an authorization; (e) of a limited data set; (f) for national security or intelligence purposes; (g) to correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody; or (h) incident to otherwise permitted or required uses or disclosures. Accounting for disclosures to dental

oversight agencies and law enforcement officials must be temporarily suspended on their written representation that an accounting would likely impede their activities.

Patient's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

FINANCIAL POLICY

FINANCIAL POLICY

Thank you for choosing us as your dental care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require that you read and sign prior to any treatment. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

INSURANCE:

Please remember your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. It is physically impossible for us to have the knowledge and keep track of every aspect of your insurance. It is up to you to contact your insurance company and inquire as to what benefits your employer has purchased for you. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.

Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays any portion.

PAYMENT:

Understand that regardless of any insurance status, you are responsible for the balance due on your account. You are responsible for any and all professional services rendered. This includes but is not limited to: dental fees, surgical procedures, tests, office procedures, medications and also any other services not directly provided by the dentist.

FULL PAYMENT is due at the time of service. If insurance benefits apply, ESTIMATED PATIENT CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made.

UNPAID BALANCE over 90 days old will be subject to a monthly interest of 1.0% (APR 12%). If payment is delinquent, the patient will be responsible for payment of collection, attorneys fees, and court costs associated with the recovery of the monies due on the account.

MISSED APPOINTMENTS:

Unless we receive notice of cancellation 48 hours in advance, you will be charged $75/hr. Please help us maintain the highest quality of care by keeping scheduled appointments.

I have read, understand and agree to the terms and conditions of this Financial Agreement.

Patient's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

COMMUNICATION CONSENTS

EMAIL CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by email regarding your Protected Health Information. Bothell Family Dentistry offers patients the opportunity to communicate by email. Transmitting patient information by email has a number of risks that patients should consider before granting consent to use email for these purposes. Bothell Family Dentistry will use reasonable means to protect the security and confidentiality of email information sent and received. However, Bothell Family Dentistry cannot guarantee the security and confidentiality of email communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with communication of email between Bothell Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bothell Family Dentistry.

Patient's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

TEXT MESSAGE TO MOBILE CONSENT FORM

PURPOSE: This form is used to obtain your consent to communicate with you by mobile text messaging regarding your Protected Health Information. Bothell Family Dentistry, offers patients the opportunity to communicate by mobile text messaging. Transmitting patient information by mobile text messaging has a number of risks that patients should consider before granting consent to use mobile text messaging for these purposes. Bothell Family Dentistry will use reasonable means to protect the security and confidentiality of mobile text messaging information sent and received. However, Bothell Family Dentistry cannot guarantee the security and confidentiality of mobile text messaging communication and will not be liable for inadvertent disclosure of confidential information.

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of mobile text messaging between Bothell Family Dentistry and myself, and consent to the conditions outlined herein. Any questions I may have, been answered by Bothell Family Dentistry.

Patient's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

HEALTH HISTORY
| DOB:

Summary

Medical Conditions	**none listed**
Allergies	**none listed**
Medications	**none listed**

We have an office mascot.

We have an office dog named Koda, do you have a dog allergy or would like to request us to keep him behind the front desk?	

General Health Information

Name of Physician/and their specialty	
Most recent physical examination	
Purpose	
What is your estimate of your general health?	
1. Have you ever been hospitalized for an injury or illness?	
2. Have you ever had an allergic reaction?	

Medical Conditions

Do you have or have you ever had	
3. Heart problems, or cardiac stent within the last six months	
4. History of infective endocarditis	
5. Artificial heart valve, repaired heart defect (PFO)	
6. Pacemaker or implantable defibrillator	
7. Orthopedic or soft tissue implant (e.g joint replacement, breast implant)	
8. Heart murmur, rheumatic or scarlet fever	
9. High or low blood pressure	
10. A stroke (taking blood thinners)	
11. Anemia or other blood disorder	
12. Prolonged bleeding due to a slight cut (or INR > 3.5)	
13. Pneumonia, emphysema, shortness of breath, sarcoidosis	
14. Chronic ear infections, tuberculosis, measles, chicken pox	
15. Breathing problems (e.g. asthma, stuffy nose, sinus congestion)	
16. Sleep problems (e.g. sleep apnea, snoring, insomnia, restless sleep, bedwetting)	
17. Kidney disease	
18. Liver disease or jaundice	
19. Vertigo (e.g. ”the room is spinning”)	
20. Thyroid, parathyroid disease, or calcium deficiency	
21. Hormone deficiency or imbalance (e.g. poly cystic ovarian syndrome)	

22. High cholesterol or taking statin drugs	
23. Diabetes	
24. Stomach or duodenal ulcer	
25. Digestive or eating disorders (e.g. celiac disease, gastric reflux, bulimia, anorexia)	
26. Osteoporosis/osteopenia or ever taken anti-resorptive medications (e.g. bisphosphonates)	
27. Arthritis or gout	
28. autoimmune disease (e.g. rheumatoid arthritis, lupus, scleroderma)	
29. Glaucoma	
30. Contact lenses	
31. Head or neck injuries	
32. Epilepsy, convulsions (seizures)	
33. Neurologic disorders (ADD/ADHD, prion disease)	
34. Viral infections and cold sores	
35. Any lumps or swelling in the mouth	
36. Hives, skin rash, hay fever	
37. STI/STD/HPV	
38. Hepatitis	
39. HIV/AIDS	
40. Tumor, abnormal growth	
41. Radiation therapy	
42. Chemotherapy, immunosuppressive medication	
43. Emotional difficulties	
44. Psychiatric treatment or antidepressant medication	
45. Concentration problems or ADD/ADHD diagnosis	
46. Alcohol/recreational drug use	
Are you	
47. Presently being treated for any other illness	
48. Aware of a change in your health in the last 24 hours (e.g., fever, chills, new cough, or diarrhea)	
49. Taking medication for weight management	
50. Taking dietary supplements	
51. Often exhausted or fatigued	
52. Experiencing frequent headaches or chronic pain	
53. A smoker, smoked previously or other (smokeless tobacco, vaping, e-cigarettes, and cannabis)	
54. Considered a touchy/sensitive person	
55. Often unhappy or depressed	
56. Taking birth control pills	
57. Currently pregnant	
58. Diagnosed with a prostate disorder	

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)	

Medications

List all medications, supplements, vitamins, and/or probiotics taken within the last two years.	
PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.	

Patient's signature: Date:

Doctor's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

DENTAL HISTORY
| DOB:

Dental History

What is your immediate concern?	
How would you rate the condition of your mouth?	
Previous Dentist	
How long have you been a patient?	
Date of most recent exam	
Date of most recent x-rays	
Date of most recent treatment (other than a cleaning)	
I rotuinely see my dentist every	

Personal History

Please answer yes or no to the following	
1. Are you fearful of dental treatment?	
2. Have you had an unfavorable dental experience?	
3. Have you ever had complications from past dental treatment?	
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	
5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	
6. Have you had any teeth removed, missing teeth that never developed or lost teeth due to injury or facial trauma?	

Gum and Bone

Please answer yes or no to the following	
7. Do your gums bleed sometimes or are they ever painful when brushing or flossing?	
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	
9. Have you ever noticed an unpleasant taste or odor in your mouth?	
10. Is there anyone with a history of periodontal disease in your family?	
11. Have you ever experienced gum recession, or can you see more of the roots of your teeth?	
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	
13. Have you experienced a burning or painful sensation in your mouth not related to your teeth?	

Tooth Structure

Please answer yes or no to the following	
14. Have you had any cavities within the past 3 years?	
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	

16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	
17. Are any teeth sensitive to hot, cold, biting, sweets, or do you avoid brushing any part of your mouth?	
18. Do you have grooves or notches on your teeth near the gum line?	
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	
20. Do you frequently get food caught between any teeth?	

Bite and Jaw Joint

Please answer yes or no to the following	
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	
22. Do you feel like your lower jaw is being pushed back when you try to bite your back teeth together?	
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	
24. In the past 5 years, have your teeth changed (become shorter, thinner, or worn) or has your bite changed?	
25. Are your teeth becoming more crooked, crowded, or overlapped?	
26. Are your teeth developing spaces or becoming more loose?	
27. Do you have trouble finding your bite, or need to squeeze, tap your teeth together, or shift your jaw to make your teeth fit together?	
28. Do you place your tongue between your teeth or close your teeth against your tongue?	
29. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	
30. Do you clench or grind your teeth together in the daytime or make them sore?	
31. Do you have any problems with sleep (i.e. restlessness or teeth grinding), wake up with a headache or an awareness of your teeth?	
32. Do you wear or have you ever worn a bite appliance?	

Smile Characteristics

Please answer yes or no to the following	
33. Is there anything about the appearance of your mouth (smile, lips, teeth, gums) that you would like to change (shape, color, size, display)?	
34. Have you ever bleached (whitened) your teeth?	
35. Have you felt uncomfortable or self conscious about the appearance of your teeth?	
36. Have you been disappointed with the appearance of previous dental work?	

Patient's signature: Date:

Doctor's signature: Date:

Bothell Family Dentistry
Michelle J. Ament DDS

Bothell Family Dentistry
19214 Bothell Way NE, Ste. B Bothell, WA 98011
(425) 486-2787
www.bothellfamilydentistry.com/

DENTAL INSURANCE INFORMATION
| DOB:

Created at: **10/23/2023 2:12:53 PM**

Primary Insurance Information

Do you have a dental insurance?	
Would you like to upload insurance card photo?	
In order to provide the best possible dental service to you and your family, Bothell Family Dentistry offers a wide choice of dental membership plans. Would you like to learn more? If you agree, we will send you a link providing more information about your options.	
Would you like to learn more about our in-house membership plan?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	
Dental Insurance Company	
ID Number	
Group Number	
Phone number on the back of your insurance card	
Address on the back of your insurance card	

Secondary Insurance Information

Do you have a secondary dental insurance?	
That's all! If you would like to add secondary insurance, you need to provide primary insurance first.	
Would you like to upload insurance card photo?	
Patient's relationship to the Insurance Holder	
Policy Holder's Name	
Policy Holder's Date of Birth	
Policy Holder's SSN	
Policy Holder's Address	
Policy Holder's City	
Policy Holder's State	
Policy Holder's ZIP	
Policy Holder's Phone Number	
Policy Holder's Employer	

Dental Insurance Company	
ID Number	
Group Number	
Phone number on the back of your insurance card	
Address on the back of your insurance card	