JAGOW FAMILY DENTISTRY
KATHRYN JAGOW, DDS

PATIENT INFORMATION

Patient name_____ Date of birth_____ Age____

Preferred name_____ Sex_____ SSN#_____

Home address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email_____

Emergency contact_____ Emergency phone_____

I would prefer appointment reminders by: □ text □ email □ both

How did you hear about us?_____

BILLING & INSURANCE INFORMATION

Billing address (if different from home)_____ City_____ State_____ Zip_____

Primary dental insurance_____ Group #_____ ID #_____

Subscriber's name_____ Date of birth_____ SSN#_____

Secondary dental insurance_____ Group #_____ ID #_____

Subscriber's name_____ Date of birth_____ SSN#_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care_____

Former Dentist _____ Date of last dental x-rays_____

Address_____ Phone_____

Are you apprehensive about dental treatment? □ Yes □ No

Have you had problems with previous dental treatment? □ Yes □ No

Are you interested in? □ Whitening your teeth □ Cosmetic treatment □ Braces or Invisalign

Are you satisfied with the appearance of your teeth? □ Yes □ No

Check (x) if you have had any of the following

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaw
□ Dentures
□ Difficulty chewing food
□ Dry mouth
□ Food collection between teeth
□ Gag easily
□ Headaches or jaw pain in morning
□ Grinding/clenching teeth
□ Loose teeth or broken fillings
□ Orthodontic treatment
□ Pain in/near ear
□ Pain due to brushing
□ Periodontal (gum) treatment
□ Sores or growths in your mouth
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sensitivity to cold
□ Tender or swollen gums
□ Tired jaws
□ Trauma to jaw
□ Trouble chewing with part of mouth

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____ Phone_____

Have you had any serious illness or operations?_____ If yes, describe_____

Have you ever had a blood transfusion? □ Yes □ No If yes, appropriate dates_____

Have you ever taken any Fosamax, Boniva, Actonel or any cancer medications containing bisphonates? □ Yes □ No

Do you use tobacco? □ Yes □ No Has your doctor told you that you need premedication? □ Yes □ No

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

Check (x) if you have or have had any of the following:

□ Anemia	□ Cough, persistent	□ Hemophilia	□ Respiratory disease
□ Angina	□ Cough up blood	□ Hepatitis	□ Rheumatic fever
□ Anxiety	□ Depression	□ High blood pressure	□ Shortness of breath
□ Arthritis, Rheumatism	□ Diabetes	□ HIV / AIDS	□ Skin rash
□ Artificial heart valves	□ Epilepsy	□ Insomnia	□ Sleep apnea
□ Artificial joints	□ Fainting	□ Kidney disease	□ Snoring
□ Asthma	□ Fatigue	□ Liver disease	□ Stroke
□ Back problems	□ GERD	□ Mitral valve prolapse	□ Swelling of feet/ankles
□ Blood disease	□ Glaucoma	□ Narcolepsy	□ Thyroid problems
□ Cancer	□ Headaches	□ Neurological disease	□ Tuberculosis
□ Chemical dependency	□ Heart attack	□ Pacemaker	□ Ulcer
□ Chemotherapy	□ Heart murmur	□ Polycystic ovarion syndrome	□ STD
□ Circulatory problems	□ Heart problems	□ Radiation treatment	

If you have a disease, condition, or problem not previously listed, please describe:

_____

_____

MEDICATIONS

List of medications you are currently taking:

_____

_____

Pharmacy name_____ Phone_____

ALLERGIES

□ Asprin, acetaminophen, ibuprofen	□ Local anesthetic	□ Latex
□ Barbituates (sleeping pills)	□ Penicillin or other antibiotics	□ Metals
□ Codeine/Narcotics	□ Sulfa	

□ Other_____

SIGNATURE

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of her staff responsible for any errors or omissions that I may have made in completion of this form.

Date_____ Signature_____

Our Financial Policy

Welcome! Thank you for choosing us as your health care provider. We are committed to your treatment being successful.

Insurance
As a courtesy to you, this office will file an insurance claim on your behalf. However, we require payment of your out-of-pocket charges at the time of service. We will attempt to maximize your dental benefits. However, your individual plan may include services or procedures which are not paid by your insurance. All fees for "non-covered" services are your responsibility. If your insurance company denies payment for any reason, you will be responsible for full payment.

Appointment Changes
Appointment times are reserved exclusively for you, so please help us serve you better by keeping all scheduled appointments. Missed appointments or last minute changes require two full business days notice. Appointment changes without notice may incur a $75.00 administrative fee. Multiple missed appointments may result in dismissal from the practice.

Finance Charges
Any balance unpaid after 30 days will be charged interest at a rate of 12% annually.

Thank you for reading and understanding our Financial Policy. Please let us know if you have any questions.

_____
Patient Name

_____ _____
Signature of Patient or Responsible Party Date

Kathryn L Jagow, DDS
22905 56th Avenue #101
Mountlake Terrace, WA 98043
(425) 776-2323

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices. The Statement of Privacy Practices describes the types and 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 this facility.

This office 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.

Name	*Relationship (circle one)*
_____	Spouse / Immediate Family / Other
_____	Spouse / Immediate Family / Other
_____	Spouse / Immediate Family / Other

_____
Patient Name

_____ _____
Signature of Patient or Responsible Party Date

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