5 Mile Smiles

"Smiles made beautiful!"

Patient: _____ Preferred Name: _____

Cell #: _____ Social Security #: _____

Date of Birth: _____ Address: _____

Email: _____ City: _____ State: _____ Zip code: _____

The benefits of a happy, healthy smile are immeasurable. Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. All information is completely confidential.

How did you hear about us?_____

What is the reason for your visit today?_____

Date of your last dental visit_____ Last dental cleaning_____ Last full mouth X-rays_____

What was done at your last dental visit?_____

How often do you have a dental examination?_____

How often do you brush your teeth?_____ How often do you floss?_____

DENTAL HISTORY

	Y	N
Are any of your teeth sensitive to:		
Sweets?	☐	☐
Hot or Cold?	☐	☐
Biting Pressure?	☐	☐
Do you get cold sores, blisters, or any other oral lesions?	☐	☐
Do your gums ever bleed or hurt?	☐	☐
Have your parents experienced gum disease or tooth loss?	☐	☐
Have you noticed any loose teeth or change in your bite?	☐	☐
Does food get caught between your teeth?	☐	☐
Does your mouth have a bad taste or odor?	☐	☐

	Y	N
Do you:		
Gag Easily?	☐	☐
Mouth breathe?	☐	☐
Frequently chew gum?	☐	☐
Clench or grind your teeth?	☐	☐
Want to replace missing teeth?	☐	☐
Wear dentures or a partial?	☐	☐
Bite your lips or cheeks?	☐	☐
Have you ever had:		
Oral Surgery?	☐	☐
Periodontal Treatment?	☐	☐
Orthodontic Treatment?	☐	☐
Your teeth or bite adjusted?	☐	☐
Serious injury to mouth or head?	☐	☐
A bite plate or mouth guard?	☐	☐

	Y	N
Have you ever expierenced:		
Pain? (joint, ear, side of face)	☐	☐
Head, neck or shoulder aches?	☐	☐
Clicking or popping in your jaw?	☐	☐
Tired jaws?	☐	☐
Difficulty opening or closing?	☐	☐
Are you apprehensive about your dental treatment?	☐	☐
Are you interested in:		
Implants?	☐	☐
Orthodontics (braces)?	☐	☐
Teeth whitening?	☐	☐
Porcelain crowns?	☐	☐
Cosmetic Dentistry?	☐	☐

HEALTH HISTORY

Medical Physician Name:
Address:
Phone number:

Biological sex: M ☐ F ☐ Gender identity_____

Please circle your marital status:

Single Married Divorced Widow

	Y	N
Do you ever smoke or use tobacco?	☐	☐

	Y	N
If female, please answer the following:		
Are you taking Birth Control Pills?	☐	☐
Are you Pregnant?	☐	☐
If yes, how many weeks?_____		
Are you nursing?	☐	☐

EMERGENCY CONTACT:

Name:	Phone #:

5 Mile Smiles **Jason Keefe, DDS**
"Smiles Made Beautiful"

HEALTH HISTORY – Continued

Conditions	Y	N	Conditions	Y	N	Conditions	Y	N
Allergies	☐	☐	Headaches	☐	☐	Sinus Problems	☐	☐
Anemia	☐	☐	Heart Attack	☐	☐	Stroke	☐	☐
Angina	☐	☐	Heart Disease	☐	☐	Thyroid Problems	☐	☐
Arthritis	☐	☐	Heart Murmur	☐	☐	Tuberculosis	☐	☐
Artificial Heart Valve	☐	☐	Heart Surgery	☐	☐	Tumors	☐	☐
Asthma	☐	☐	Hepatitis A	☐	☐	Ulcers	☐	☐
Back / Neck Pain	☐	☐	Hepatitis B	☐	☐			
Breathing Difficulty	☐	☐	Hepatitis C	☐	☐	**Allergies**	Y	N
Blood Transfusion	☐	☐	High Blood Pressure	☐	☐	Aspirin	☐	☐
Bruise Easily	☐	☐	Joint Replacements	☐	☐	Codeine	☐	☐
Cancer – Chemotherapy	☐	☐	Kidney Problems	☐	☐	Dental Anesthetics	☐	☐
Cold Sores	☐	☐	Liver Disease	☐	☐	Erythromycin	☐	☐
Diabetes	☐	☐	Low Blood Pressure	☐	☐	Jewelry	☐	☐
Drug Abuse	☐	☐	Mitral Valve Prolapse	☐	☐	Latex	☐	☐
Eating Disorder	☐	☐	Nervousness / Anxiousness	☐	☐	Metals	☐	☐
Emphysema	☐	☐	Osteoporosis	☐	☐	Penicillin	☐	☐
Epilepsy	☐	☐	Pace Maker	☐	☐	Tetracycline	☐	☐
Excessive Bleeding	☐	☐	Psychiatric Care	☐	☐			
Fainting Spells	☐	☐	Radiation Therapy	☐	☐	**Other Allergies:**		
Glaucoma	☐	☐	Rheumatic Fever	☐	☐			
HIV+ AIDS	☐	☐	Seizures	☐	☐			
Hay Fever	☐	☐	Sexual Disease	☐	☐			

Have you been treated with intravenous biophosphonates such as zometa or aredia?	Y	N
	☐	☐

Medications Currently Taking:

Is there any disease, condition, **or problem that you think this office should know about that is not covered above?**
If yes, please describe:

Insurance Co. & Phone Number:

Insured Name:

Insured Birthday:

Insured 10# or Social Security #:

Signature: **Date:**

Five Mile Smiles
1625 W. Francis
Spokane, WA 99205
(509) 326-2621

Financial Policy

We would like to welcome you to our dental practice and explain our financial policy. We believe that service to our patients is best when there is complete understanding and mutual cooperation.

Our patients can expect from us:

1. A high degree of professional skill and ability.
2. A team that continually stays abreast of progress in the dental sciences.
3. A team that will perform all services to the best of our ability and knowledge.
4. A complete explanation of the findings that result from a thorough examination and diagnosis. We will discuss all fees prior to the start of treatment.

In return, we expect from our patients:

1. Cooperation in making and keeping appointments.
2. A conscientious effort to follow home care and oral hygiene instructions.
3. To follow the recommended recare interval, based on your needs.
4. A definite arrangement for the payment of fees.

We ask that you cover your portion of fees at the time you receive treatment. You may either pay by cash, check or use a personal credit card. If you do not have insurance, please be prepared to fully cover the fees for each visit.

If you have insurance, we will process your insurance benefits as a courtesy to you. We ask that you pay the portion of your treatment not covered by insurance along with any deductible. It is your responsibility to verify the amount of coverage you have and to review your monthly statement to make sure your insurance company has paid. It generally takes four to six weeks to receive the insurance payment. If there is a problem, just call us and we will do our best to help.

We want you to receive the best dentistry and we want to make it affordable. If you need help prioritizing your dental treatment, please let us know.

I agree, I am fully responsible for the total payment of all procedures in this office, this includes treatment that is not a benefit of my dental insurance. I understand if at any time credit is extended to me, a credit check may be made through a credit service. I authorize release of all financial data. I will be responsible for finance and/or collection charges as they apply. An interest rate of 18% APR will be applied to all accounts over 60 days regardless of the insurance involvement.

Signature_____ Date _____

5 Mile Smiles
1625 W. Francis Avenue
Spokane, WA 99205

Jason Keefe, D.D.S.
Phone 509.326.2621
Fax 509.325.5796

HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act - 45 CFR Parts 160 and 164)

1. I hereby authorize Dr. Jason Keefe and associates to share my dental records with my insurance company(s) for billing purposes and other health care providers if I am referred out for specialty treatment.
    a. This information may be used by the persons I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
2. I authorize disclosure of information regarding my billing, condition, treatment and prognosis to the following individual(s):

    Name _____ Relationship _____

    Name _____ Relationship _____

3. This authorization shall be in force and effect until I revoke permission.
    a. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
4. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
5. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

MESSAGES

Please call my: ☐ Home _____ ☐ Work _____

☐ Cell _____ ☐ Email _____

If unable to reach you may we leave a detailed message? ☐ Yes ☐ No

Best time to reach me is *(day)* _____ between *(time)* _____

Print Name: _____ **Date of Birth:** _____

Signature of Patient: _____ **Date:** _____