WELCOME

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. The better we communicate, the better we can care for you.

About You

Today's Date: _____ E-mail Address: _____

Name: _____ I prefer to be called: _____ ❑ Male ❑ Female
Last First Mi Mr Mrs Ms Dr

Birthdate: ___/___/___ Age: _____ Social Security #: _____ ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Home Address: _____
Street City State Zip

Home Phone #: (____)_____ Pager/Car #: (____)_____ Work Phone #: (____)_____ Ext: ____ Driver's License #: _____

Where & when are best times to reach you? _____ Whom may we thank for referring you? _____

Other family members seen by us: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____
Street/PO Box City State Zip

Neighbor or Relative not living with you

His / Her Name: _____ Relation: _____ Work Phone #: (____)_____ Home Phone #: (____)_____

Address: _____
Street City State Zip

Spouse Information

His / Her Name: _____ Birthdate: ___/___/___ Social Security #: _____

Employer: _____ Work Phone #: (____)_____ Ext: _____ Driver's License #: _____

Insurance Information

Primary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's ID #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

Secondary Insurance Dental Coverage? ❑ Yes ❑ No Orthodontic Coverage? ❑ Yes ❑ No Medical Coverage? ❑ Yes ❑ No

Insurance Co. Name: _____ Phone #: (____)_____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/PO Box City State Zip

Insured's Name: _____ Insured's ID #: _____ Insured's Birthdate: ___/___/___ Relation: _____

Insured's Employer: _____ Employer's Address: _____
Street/PO Box City State Zip

CONTINUED ON BACK

Dental History

Why have you come to the dentist today? _____

_____

Are you currently in pain? ❑ Yes ❑ No

Do you require antibiotics before dental treatment? ❑ Yes ❑ No

Your current dental health is ❑ Good ❑ Fair ❑ Poor

Do you floss daily? ❑ Yes ❑ No Brush daily? ❑ Yes ❑ No

Type of bristles on your toothbrush? ❑ Hard ❑ Medium ❑ Soft

Do your gums ever bleed? ❑ Yes ❑ No Ever Itch? ❑ Yes ❑ No

Have you ever had periodontal disease? ❑ Yes ❑ No

Are your teeth sensitive to heat, cold, or anything else? _____

Do you have mobility in your teeth? ❑ Yes ❑ No

Do you still have wisdom teeth? ❑ Yes ❑ No

Previous / Present Dentist: _____ Last Visit Date: _____
(Please Circle)

Would you like fresher breath? ❑ Yes ❑ No Whiter teeth? ❑ Yes ❑ No

Are you happy with the way your smile looks? ❑ Yes ❑ No

If not, what would you change? _____

_____

Medical History

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____
Street

_____
City State Zip

Phone #: (___)_____ Date of last visit: _____

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Have you ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Unsure ❑ Yes ❑ No

Week #: _____ Are you nursing? ❑ Yes ❑ No

Do you or have you experienced the following?

Y N Abnormal Bleeding	Y N Colitis	Y N Hay Fever	Y N Liver Disease	Y N Shingles
Y N Alcohol Abuse	Y N Congenital Heart Defect	Y N Headaches	Y N Low Blood Pressure	Y N Sickle Cell Disease
Y N Anemia	Y N Diabetes	Y N Heart Attack	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Breathing	Y N Heart Murmur	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Heart Surgery	Y N Pacemaker	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hemophilia	Y N Persistent Cough	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Hepatitis	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Ever Hospitalized	Y N Herpes	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fainting Spells	Y N High Blood Pressure	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Fever Blisters	Y N HIV+/AIDS	Y N Scarlet Fever	Y N Venereal Disease
Y N Chicken Pox	Y N Glaucoma	Y N Kidney Problems	Y N Seizures	

Please list any serious medical condition(s) that you have experienced: _____

Are you taking any prescription/over the counter drugs? ❑ Yes ❑ No If yes, please list each one: _____

_____

Are you allergic to any of the following?

Y N Aspirin	Y N Codeine	Y N Erythromycin	Y N Latex	Y N Sedatives	Y N Tetracycline
Y N Barbiturates	Y N Dental Anesthetics	Y N Jewelry / Metals	Y N Penicillin	Y N Sulfa Drugs	Y N Other

Please list anything additional that causes allergic reactions: _____

_____

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.
I have received a copy of this offices Notice of Privacy Practices.

_____
Signature Date

I authorize the use, disclosure, and release of my personal and protected health information by Dr. Beth A. Gold and her employees for the purposes of treatment, payment and health care operations. I understand that I may request in writing that you restrict how my private information is used and I understand that I may revoke this consent in writing at any time, except to the extent that I have taken action relying on this consent.

_____
Signature Date

Beth A. Gold, DDS & Amir Emam, DDS

5100 Grove Street Suite A, Marysville, WA 98270
Phone: 360-659-6732 Fax: 360-653-6835
scheduling@bethagolddds.com www.bethagolddds.com

Financial Policy

Welcome! Thank you for entrusting us as your healthcare provider. We encourage you to ask questions and to be involved in treatment decisions, while we help educate you about your oral health. In the interest of good healthcare practice, it is desirable to establish a policy to avoid misunderstandings. Therefore we wish to clarify the following points :

Please initial the following indicating you have read each section carefully.

Insured Patients

INITIALS

1. We are in-network with **Cigna, Delta Dental** & most **Regence** plans. As a courtesy we are able to bill most out-of-network plans however some, like most **Premera** plans do not make payments to out-of-network providers. Payments are made directly to you and therefore, we do collect full fees at the time of service. Unfortunately, we are not able to bill **Medicare** but will happily provide documentation so that you may do so.
2. As a courtesy to you, we will bill your dental insurance company. It is important to understand that your insurance policy is a contract between you and your insurance company and be aware that we are not a party to that contract. Should your insurance not make payment, you are responsible for the charges incurred for your visit. If a claim is not paid within 90 days of the service date you will be responsible for the total charges.
3. All copays, coinsurance and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance carrier.
4. Dr. Gold and Associates main concern is your dental health and are confident in recommending treatment based on that premise, however, your insurance plan may consider some procedures as “non-covered” or “not necessary”. Dr. Gold and Associates do not diagnose treatment needs based on what insurance deems “necessary”.
5. You are responsible for monitoring your dental benefits. With regard to your maximum, be sure to inform us of all the paid benefits that have been sent to other dental establishments (i.e. Your general dentist, oral surgeon or other specialists.)
6. If you have a change in coverage, please notify us immediately so we can make the appropriate changes and expedite the processing of your claim.

Non-Insured Patients

INITIALS

1. Please note all charges incurred are due and payable in full on the date treatment is rendered.
2. We offer a 5% Senior courtesy to patients over age 65 when services are paid with cash or check. We cannot offer this discount if paying via credit card.
3. We offer interest free options with our partnership through Care Credit *(terms apply)*.

Payment Options

INITIALS

1. We accept all major Credit cards, Care Credit, Cash or Check. Please be aware if paying by Cash we do not have the ability to offer change, Cash is not kept on the premises.
2. We understand life is busy! We now offer secure payment solutions available via text or email.

_____
INITIALS

Usual and Customary Rates

1. Beth Gold and Associates are committed to providing the best treatment for our patients at a fair rate. We have submitted our office fees to Fairhealthconsumer.org and have determined to be within the guidelines of "usual and customary" for our area.
2. You are responsible for all unpaid balances, regardless of any insurance companies arbitrary determination of "usual and customary rates".

_____
INITIALS

BROKEN Appointments

1. A broken appointment constitutes as: Not showing up, Canceling without 24hr notice or arriving 15 minutes or later tardy. We make every effort to confirm appointments however, ultimately it is the responsibility of the patient to keep track of scheduled visits.
2. Frequent broken appointments may result in a **$100/hr** fee for hygiene appointments and **$250/hr** fee for surgical appointments.
3. We do not accept voicemails or texts to cancel appointments, please call during business hours to modify appointments.

I have read and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account. I agree that in the event costs and/or fees that are incurred in connection with the collection of my account, I will pay all such costs and fees.

_____ _____

Print Name of Patient Date

_____

Signature of Patient or Legal Guardian

Beth A. Gold DDS
5100 Grove St. Suite A
Marysville WA 98270
PH- 360-659-6732 EM- Scheduling@bethagolddds.com

AUTHORIZATION FORM

Authorization to Leave Voicemails/Emails

Our office may need to contact you regarding test results, appointments, referrals, or billing/insurance information. To protect your privacy and follow federal guidelines, Please select from the following:

- ☐ **DO** leave detailed messages regarding my care.
- ☐ **DO NOT** leave detailed messages regarding my care.

Phone _____ Email_____

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request treatment or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your treatment or billing records released to family members you must sign this form. Signing this form will only provide documents to family members indicated below and can be retracted at any time.

Name:_____Relation:_____

Name:_____Relation:_____

Dental Records Release

Oftentimes it is necessary to obtain your complete dental history in order to devise a treatment plan that will properly address all of your immediate and long term dental needs. This consent gives **Beth A Gold and Associates** permission to obtain your records on your (or your dependants) behalf.

Previous Dental Office:_____Phone:_____

Patient Name:_____DOB:_____

By signing, I am authorizing **Beth A Gold and Associates** to obtain and disclose my dental records in the above listed manner of my selection. I understand that this authorization form may be revoked in writing at any time.

_____DOB:_____
Print Name of Patient or Legal Guardian

_____Date:_____
Signature of Patient or Legal Guardian