FAITH R BULT, DDS

405 32nd Street, Suite 100
Bellingham, WA 98225

360-715-3333
360-715-8338

Patient Information

Patient Name: ______________________________ Date: ___________
Last, First MI (Preferred Name)

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Phone (Home): ______________ (Work): ______________ Ext: ________ (Cell) ______________

Email Address: ______________________________ Drivers License: ______________

Social Security #: ______________________________ Birth Date: ______________

Emergency Contact: ______________________________ Phone ( ) ______________

Health Information

Date of Last Dental Visit: __________ Reason for this visit: ______________ Previous Dentist: __________

Have you ever had any of the following? Please check those that apply:

☐ AIDS / HIV
☐ Allergies __________
____
☐ Anemia
☐ Arthritis
☐ Artificial Joints
☐ Asthma / Respiratory Problems
☐ Blood Disease
☐ Cancer
☐ Codeine Allergy
☐ Diabetes
☐ Dizziness
☐ Epilepsy
☐ Excessive Bleeding
☐ Fainting
☐ Glaucoma
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Kidney Disease
☐ Latex Allergy
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Pacemaker
☐ Penicillin Allergy
☐ Pregnant
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatism
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Sulfa Allergy
☐ Tuberculosis
☐ Tumors / Growths
☐ Ulcers
☐ Venereal Disease

OTHER:
☐ ______________
☐ ______________

- Are you currently taking any medications or supplements? ☐ Yes ☐ No
  If yes, please list: ______________________________
- Have you ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: ______________________________
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: ______________________________

  Name of Physician: ______________________________ Phone: ______________
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: ______________________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

______________________________ Date: ______________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient: _________________ ☐ Yellow Pages
☐ Dental Office: _________________ ☐ Newspaper ☐ School ☐ Work ☐ Other _________________

Spouse or Responsible Party Information

The following is for: ☐ the patient's spouse ☐ the person responsible for payment

Name: ____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ________________

Address: ____
Street Apartment #

____
City State Zip Code

Phone (Home): ________________ (Work): ________________ Ext: ______ (Cell): ____________________

Social Security #: ________________________________ Birth Date: ________________________________

Employer Name: ____________________________________ Occupation: ____________________________

Insurance Information

Primary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: ____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Insurance Plan Name and Address: ____

Secondary

Name of Insured: ____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _________________ ID #: _____________________ Group #: ____________________

Insured's Address: ____
Street City State Zip Code

Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ___________________

Insurance Plan Name and Address: ____

Consent for Services

I authorize the Dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. All procedures have risks, these include, but are not limited to: drug reactions/side effects, damage to adjacent teeth or fillings, post operative sensitivity to temperature and/or pressure, bruising/pain/swelling, failure of dental procedure, necessitating additional treatment, complications during treatment necessitating referral to a specialist. I understand that diagnostic radiographs are necessary to ensure optimum dental health. I will not hold the Dentist liable for any failure to diagnose, or any misdiagnosis due to my refusal for recommended x-rays. I will take full responsibility for any conditions relating to my dental health that may not have been diagnosed or misdiagnosed due to lack of radiographs. I hereby release from liability, the Dentist and her employees and agents from injury that I may currently, or in the future, suffer as a result of my refusal to proceed with any recommended dental treatment. I authorize and consent to any x-rays, examination, anesthetics, sedative, or dental treatment rendered for myself and/or children under the general, direct, or indirect supervision of the Dentist. I authorize photographs, x-rays and other records made during the course of my examination, treatment, and follow-up care to be used for purposes of research, education or publication in professional journals.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from all patients for the costs incurred in their care. The financial responsibility on the part of each patient must be determined before treatment. All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally and ultimately responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. I hereby authorize payment of insurance benefits directly to the Dentist, otherwise payable to me. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. I authorize release of any information concerning my (or my child's) health care, advice and treatment provided for the purpose of evaluation and administering insurance benefits. In consideration for the professional services rendered to me, or at my request, by the Dentist, I agree to pay therefore the reasonable value of said services to said Dentist, or her assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs, finance charges and reasonable attorney fees if suit be instituted hereunder. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination. I grant my permission to the Dentist or her assignee, to telephone me at home or at my work to discuss matters related to this form or treatment. I attest to accuracy of information on this page. To the best of my knowledge all of the preceding answers are true and correct. If I ever have any change in my health, or if my medicines change, or if any information on this form change, I will inform the Dentist at the next appointment without fail.

I have read the above conditions of treatment and payment and agree to their content.

____ Date: _____________ Relationship to Patient: ____________________
Signature of patient, parent, guardian or guarantor