Lisa L. Buttaro DDS, MAGD | Fife Dental Center
6106 20th St E | Tacoma, WA 98424 | (253) 926-3803

# Dental Registration

Date _____ Home Phone # _____

## Patient Information

Email _____

Name _____ Cell Phone # _____
Last Name First Name Initial

Address _____

City _____ State _____ Zip _____

Sex ☐ M ☐ F Age _____ Birthdate _____ ☐ Single ☐ Married ☐ Widowed
☐ Separated ☐ Divorced

Patient Employed By _____ Occupation _____

How would you prefer to be contacted? Email Text Home Phone Cell Phone

Whom may we thank for referring you? _____

Emergency Contact _____ Phone _____

## Primary Insurance

Person Responsible for Account _____
Last Name First Name Initial

Relationship to Patient _____ Birthday _____ Soc. Security # _____

Address (if different from patient's _____

City _____ State _____ Zip _____

Person Responsible Employed By _____ Driver's Liscence # _____

Business Address _____ Business Phone _____

Insurance Company _____

Phone # _____ Group # _____ Subscriber ID# _____

Is patient covered by additional insurance? Yes No

Subscriber Name _____ Relationship to Patient _____ Birthdate _____

Insurance Name _____ Insurance Phone _____

Subscribert ID # _____ Group # _____

## Authorization

I authorize my insurance company to pay the dentist all insurance benefits otherwise payable to me for service rendered. I authorize the use of this signature on all Insurance submissions. I authorize the dentist to release all information necessary to secure the payment for benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. We do not bill ex-spouses. The parent that brings in the child is responsible for payment of service. We charge interest of 1% per month on past due accounts. We charge a $20.00 NSF check fee. We refer NSF checks to the Pierce County Prosecuting Attorney's office for collection.

**A FEE OF $50 PER HOUR MAY BE BILLED FOR BROKEN APPOINTMENTS OR CANCELLATIONS WITHOUT 48 HOURS NOTICE.**

Signature _____ Date _____

Patient portion for treatment is due in full at time of treatment.

Lisa L. Buttaro DDS, MAGD | Fife Dental Center
6106 20th St E | Tacoma, WA 98424 | (253) 926-3803

# Health History

Name _____ Date _____

Date of last health care exam: _____ What was the exam for? _____

Have you been hospitalized in the last 5 years? No Yes

If yes, reason: _____

Are you currently receiving care? No Yes If yes, nature of care: _____

Please list all the names and phone numbers of the physicians who are currently providing you care:

_____

*For the following questions circle yes or no. Your answers are for our records only and will be confidential. Please note that during your initial visit you will be asked some questions about your response. Our team may ask additional questions concerning your health.*

| | | | | | |
|---|---|---|---|---|---|
| Anemia or Blood Disorder? | No | Yes | High Cholesterol | No | Yes |
| Arthritis, Rheumatism or other inflammatory disease? | No | Yes | Joint Replacement? When placed? | No | Yes |
| Asthma | No | Yes | Kidney Disease | No | Yes |
| Abnormal Bleeding from a cut? | No | Yes | Liver Disease (including Jaundice) | No | Yes |
| Cancer or Tumor? | No | Yes | Sore/Enlarged Lymph Nodes | No | Yes |
| Diabetes | No | Yes | Psychiatric Treatment | No | Yes |
| Emphysema or other Respiratory/Lung Illnesses | No | Yes | Previous Biopsies | No | Yes |
| Epilepsy | No | Yes | Radiation or Chemotherapy Treatment | No | Yes |
| Fainting or Dizzy Spells | No | Yes | Rheumatic Fever | No | Yes |
| Glaucoma | No | Yes | Slow-Healing Mouth Sores | No | Yes |
| Abnormal Heart or Previous Bacterial Endocarditis | No | Yes | Stroke | No | Yes |
| Heart Valve (artificial) or Heart Transplant | No | Yes | Thyroid Issue | No | Yes |
| Congenital Heart Disease | No | Yes | Unintentional Weight Loss/Gain | No | Yes |
| Heart Disease, Heart Attack, Heart Surgery | No | Yes | H.I.V. Infection/AIDS or ARC | No | Yes |
| Heart Stent? When placed? _____ | No | Yes | Venereal Disease | No | Yes |
| Hepatitis, Any Form | No | Yes | Other Conditions | No | Yes |
| | | | Recurrent Illnesses | No | Yes |

Are you taking any of the following medications?

| | | | | | |
|---|---|---|---|---|---|
| Pre-medication before dental treatment? | No | Yes | Tagamet® (cimetidine) or Prilosec® (omeprazole)? | No | Yes |
| Antacids? | No | Yes | Cardizem® (diltiazem) or Calan, Isoptin® (Verapamil)? | No | Yes |
| Dilantin® or Tegretol® | No | Yes | Serzone® (nefazodone) | No | Yes |
| Barbiturates (any) | No | Yes | Diflucan® (fluconazole) or Sporonox® (itraconazole) | No | Yes |
| St. John's Wort or Kava-Kava? | No | Yes | Biaxin® (clarithromycin) | No | Yes |

Have you been treated with Bisphosphonate drugs (Fosamax®, Aredia®, Zometa®, Actonel®, Boniva®)? No Yes
If so, when did the treatment begin? _____ When did the treatment end? _____ No Yes
Have you ever taken any prescription drugs such as fen-phen for weight loss? No Yes
Do you consume grapefruit juice, grapefruits or grapefruit extract? No Yes

Please list any medications you are currently taking and dosages:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____
7. _____ 8. _____

Please list any dietary or herbal supplements you are taking and for what purpose:

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Lisa L. Buttaro DDS, MAGD | Fife Dental Center
6106 20th St E | Tacoma, WA 98424 | (253) 926-3803

Women: Are you pregnant? No Yes
If no, are you planning a pregnancy in the near future? No Yes
Are you a nursing mother? No Yes
Are you taking birth control pills? No Yes

Abnormal Blood Pressure? No Yes
Have you ever received a diagnosis of "high blood pressure"? No Yes
What is your normal blood pressure? _____ S _____/D Today: _____/_____

Are you allergic or have you had a reaction to:
a. Local anesthetics No Yes
b. Penicillin or other antibiotics No Yes
c. Aspirin, Ibuprofen or Tylenol No Yes
d. Codeine, Valium or other sedatives No Yes
e. Latex or Metals No Yes
f. Other (please specify)

Tobacco, Alcohol, Drugs
Do you use tobacco? If yes, circle type: smoke chew How much per day? _____ For how long? _____ No Yes
Do you want to quit using tobacco? No Yes
Do you consume alcohol? If yes, approximately how many alcoholic beverages per week? _____ No Yes
Do you use any mood altering drugs other than those previously listed? No Yes

Weight and Diet considerations
Dietary Restrictions Food Allergies

_____ _____
_____ _____

Sugar in your diet: ☐ none ☐ slight ☐ moderate ☐ high

**DOCTOR'S USE ONLY**
Comments on patient interview concerning medical history:

_____
_____

Significant findings from questionnaire or oral interview:

_____
_____

Dental management considerations:

_____
_____

*I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of change in my health and medication.*

_____
Patient (print name) Patient Signature Date

_____
Doctor (print name) Doctor Signature Date

Lisa L. Buttaro DDS, MAGD | Fife Dental Center
6106 20th St E | Tacoma, WA 98424 | (253) 926-3803

# Office Policies

Please review Fife Dental Center's office policies. Read and initial each policy, print, sign and date form.

_____ In order to be in compliance with current OSHA regulations only patients being treated are allowed in the operatory. This includes parents who will need to wait in the waiting room for their child unless asked to come back. Also parents who have children being treated cannot leave the office or we will not be able to treat them.

_____ Office policy requires 48 hours notice to cancel an appointment. If you have a late cancellation, we reserve the right to charge you $50.00 per hour for the appointment. If you fail an appointment, $50.00 per hour will be billed to you, If you are more than 10 minutes late to your hygiene appointment, we may have to reschedule your appointment to keep the next patient from waiting.

_____ Patient portion is due at the time of service. A late payment fee and re-billing fee will be charged on delinquent accounts (over 90 days). We provide insurance billing as a courtesy to you. However, if there is no payment from your insurance company to our office within 60 days you are responsible for the balance in full at that time. We are not able to negotiate with your insurance company on your behalf.

_____ All lab procedures require 1/2 down at start of procedure and remaining balance due at seat appointment.

_____ You will need to provide our office with your social security number and health insurance card (if applicable) unless your total charge is paid in cash at time of service. Treatment may be postponed if the above are not furnished by the patient.

_____ Unless otherwise agreed upon all accounts over 120 days will be assigned to a collection agency. A $50 collection fee will be charged to your account once assigned.

I have read and understand Fife Dental Center Policies.

_____

Patient Name

_____ _____

Patient/Guardian Signature Date