Welcome to Swenson Dental!

Thank you for choosing us to care for you and your family's oral health care needs! Our entire team is dedicated to providing you with the personalized, gentle care that you deserve.

Swenson Dental clinic has been in operation for over 40 years, Dr. Aaron Swenson, DDS followed in in father's footsteps and purchased Swenson Dental from his father, Dr. Vern Swenson, DDS (retired) in 2011. Dr. Aaron and his team continue strive to ensure a legacy and to help you meet all your dental needs.

Our mission has always been to serve you, our patient, and provide you with the exclusive attention while striving to always foster this relationship. We take pride in our ability to provide you with optimal dental care designed for your unique needs and desires. We want to help you make informed choices, by fully understanding any problems or treatment plans you may be needing.

Our staff is dedicated in making your experience in the office not only comfortable but also affordable. Our office staff can work with patients who have dental insurance to navigate any questions, and help you reach your maximum benefits in which you are entitled too. It is the patient responsibility to provide payment in full at the time of service unless another financial agreement has been made. For your convenience we do accept most major credit cards as well as Care Credit.

We are excited to meet you, please feel free to reach out to our clinic at any time with any questions you may have.

Thank you again for choosing our dental practice!

-Swenson Dental Staff-

*Appointment Date & Check in Time:*_____

Patient Name	**DENTAL HISTORY**
Patient Account No.	**Medical Alert**

Welcome! Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care.
All information is completely confidential.

What is the reason for your visit today? _____

_____

Date of Last Dental Visit? _____ Last Dental Cleaning _____ Last Full Mouth X-rays _____

What was done at your last dental visit? _____

Previous Dentist's Name _____ Telephone _____

Address _____ State _____ Zip _____

How often do you have dental examinations? _____

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

Have you ever used or are you currently using topical fluoride? ☐ Yes ☐ No

What other dental aids do you use (Interplak, toothpick, etc.)? _____

Do you have any dental problems now? ☐ Yes ☐ No

If yes, please describe: _____

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Have your parents experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth?	☐ Yes	☐ No

If yes, where? _____

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or use other tobacco products?	☐ Yes	☐ No

Have you ever had:

Orthodontic treatment?	☐ Yes	☐ No
Oral surgery?	☐ Yes	☐ No
Periodontal treatment?	☐ Yes	☐ No
Your teeth ground or the bite adjusted?	☐ Yes	☐ No
A bite plate or mouth guard?	☐ Yes	☐ No
A serious injury to the mouth or head?	☐ Yes	☐ No

If yes, please describe, including cause _____

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain (joint, ear, side of face)?	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Headaches, neck aches or shoulder aches?	☐ Yes	☐ No
Sore muscles (neck, shoulders)?	☐ Yes	☐ No
Are you satisfied with your teeth's appearance?	☐ Yes	☐ No
Would you like to keep all of your teeth all of your life?	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe _____

Have you ever been told to take a pre-medication prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe _____

PLEASE COMPLETE OTHER SIDE

Patient Name

Patient Account No.

MEDICAL HISTORY

Medical Alert

1. Physician's Name _____ Phone ( ) _____
   Have you had any medical care within the past two years? ☐ Yes ☐ No
   Describe _____
2. Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No
3. Are you currently taking an medication, drugs, pills or herbal remedies, including regular dosages of aspirin? ☐ Yes ☐ No
4. Have you ever taken prescription medications for weight loss (diet pills)? ☐ Yes ☐ No
   If yes, did you take any of the following? (Check if yes) ☐ Fen-Phen ☐ Pondimen ☐ Redux ☐ Other
   If yes to any of the above, did you have a medical exam for heart issues? ☐ Yes ☐ No
5. Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other similar drugs? ☐ Yes ☐ No
6. Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No
   If yes, please specify _____
7. Have you been a patient in the hospital during the past five years? ☐ Yes ☐ No
8. Indicate which of the following you have had, or have at present. Check "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes ☐ No	Kidney Trouble	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Chest Pain	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No	AIDS/HIV Positive	☐ Yes ☐ No
Congenital Heart Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Cold Sores/Fever Blisters	☐ Yes ☐ No
Heart Murmur	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No	Blood Transfusion	☐ Yes ☐ No
High/Low Blood Pressure	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No
Mitral Valve Prolapse	☐ Yes ☐ No	Contact Lenses	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve/ Pacemaker	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Bruise Easily	☐ Yes ☐ No
Rheumatic Fever	☐ Yes ☐ No	Chronic Cough	☐ Yes ☐ No	Liver Disease/Yellow Jaundice	☐ Yes ☐ No
Arthritis/Rheumatism	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No	Neurological Disorders	☐ Yes ☐ No
Cortisone Medicine	☐ Yes ☐ No	Asthma	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No
Swollen Ankles	☐ Yes ☐ No	Hay Fever/Allergy/Hives	☐ Yes ☐ No	Fainting or Dizzy Spells	☐ Yes ☐ No
Stroke	☐ Yes ☐ No	Latex Sensitivity	☐ Yes ☐ No	Nervous/Anxious	☐ Yes ☐ No
Diet (Special/Restricted)	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No	Psychiatric/Psychological Care	☐ Yes ☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes ☐ No	Radiation Therapy	☐ Yes ☐ No		
		Chemotherapy	☐ Yes ☐ No		
		Tumors	☐ Yes ☐ No		
		Hepatitus A, B, C	☐ A ☐ B ☐ C		

9. Have you lost or gained more than 10 pounds in the last year? ☐ Yes ☐ No
10. Do you have or have you had any disease, condition, or problem not listed? ☐ Yes ☐ No
11. Women: Are you pregnant or think you could be pregnant? ☐ Yes ____ Months ☐ No Nursing? ☐ Yes ☐ No
12. Do you use birth control prescriptions? ☐ Yes ☐ No

I understand the above information in 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 any change in my health or medication.

Patient / Guardian Signature _____ Date _____

History Review

Dentist Signature _____ Date _____

LIST OF CURRENT MEDICATIONS

Medication (Brand and Generic Name)	*Dose*	*How Often You Take the Medication*	*Reason for taking*

DR.Aaron M. Swenson DDS

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is available upon request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting the Privacy Officer at our office.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Privacy Officer at our office. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE - I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Patient Name: _____ **Date**: _____

Patient or Legal

Guardian Signature: _____

Relation to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

General Consent Form for Dental Procedures

You, the patient, have the right to accept or reject dental treatment recommended by your dentist. Prior to consenting to treatment, you should carefully consider the anticipated benefits and commonly known risks of the recommended procedure, alternative treatments, or the option of no treatment. Do not consent to treatment until you discuss potential benefits, risks, and complications with your dentist, and all of your questions are answered. By consenting to the treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence. It is very important that you provide your dentist with accurate information before, during, and after treatment. It is equally important that you follow your dentist's advice and recommendations regarding medication, pre and post-treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read all items below and sign at the bottom of the form.

1. Treatment to be provided
I understand that during my course of treatment that the following care may be provided:
examinations, preventative services, diagnosis, basic restorative, and crowns.

2. Drugs and Medications
I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).

3. Changes in Treatment
I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the dentist to make any/all changes and additions as necessary.

4. Bill Insurance
I give permission to the dental office to bill my dental insurance provider for the treatment provided, if applicable.

Signature of Patient: _____Date:_____

Relationship to patient if not self:_____

Dr. Aaron M. Swenson DDS

FINANCIAL POLICY

This is an agreement between Dr. Aaron M. Swenson DDS, and the Patient named on this form. In this agreement the words "you," "your," and "yours" mean the Patient. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Dr. Aaron M. Swenson DDS.

By executing this agreement, you the patient, are agreeing to pay for all services that are received.

Payment options for CASH (no insurance billed) patients:

1. **You may choose to pay by cash, check, or credit card on the day that treatment is rendered**. A 5% discount will be given for cash or check payment on day of treatment, 10% for seniors.
2. **On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you are required to pay at least 50% on the preparation appointment and the balance at the delivery appointment.**
3. On extensive treatment, you may prefer to secure a bank, credit union, or other third-party financing for the entire amount and make payments to the lending institution such as **CARE CREDIT.**

Payment options if you have insurance:

1. **You are expected to pay your deductible and any out-of-pocket portions at the time of service either by cash, check, or credit card**.
2. On treatment involving laboratory fees (**crowns, bridges, dentures, etc**.) **you are required to pay at least 50%** of your out-of-pocket portion at the start or preparation appointment, and the balance on the completion or delivery appointment. (Normally two weeks later.)

Contracted (PPO) or Non-contracted Insurance: We will always do our best to help you maximize your benefits and we will bill your insurance company as a **COURTESY** to you. Although we file claims for you as a courtesy, your dental insurance policy is a contract between you, your employer, and your insurance company. Not all services are covered benefits in all contracts. We must follow the insurance contract and their requirements. If you have a co-pay or deductible, you must pay that at the time of service. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. **You agree to pay any portion of the charges not covered by insurance**. It is your responsibility to thoroughly understand the coverage and exceptions of your particular policy. Coverage issues can only be addressed between you, your employer, or group plan administrator. We cannot act as mediator with the carrier or your employer.

Claims filing process:
Your claim will be filed immediately on the date treatment is completed and benefits are expected to be paid within 30-45 days. The filing of an insurance claim does not relieve you of timely payment on your account. If the claim is not cleared by your carrier in 60 days, the unpaid portion will automatically become "self pay" and a statement will be issued to you for the unpaid portion. You are responsible for any amounts your insurance company chooses not to pay for whatever reason.

Late Fee: A Late Fee of $25 will be imposed on each account that is over ninety (90) days past-due. Every successive month overdue will incur another late fee charge

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyers' fees which we incur plus all court costs. In case of a lawsuit, you agree the venue shall be in Clallam County, Washington.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Returned checks: There is a fee (currently $25) for any checks returned by the bank.

Missed appointment policy: Patients with three missed appointments without at least 24 hour notice may be dismissed from our practice.

Divorce: In case of divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. After a divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

Transferring of Records: You will need to request in writing, and pay a reasonable copying fee if you want to have copies of your records sent to another doctor or organization. The amount of the fee is dependent on the number of pages we need to copy. You authorize us to include all relevant information, including your payment history. If you are requesting your records to be transferred from another doctor or organization to us, you authorize us to receive all relevant information, including your payment history.

Workers Compensation: We require written approval/authorization by your employer and/or worker's compensation carrier prior to your initial visit. *If your claim is denied, you will be responsible for payment in full.*

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your health insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient's name: _____

Responsible party (if not the patient): _____

Signature: _____ **Date:** _____

Co-Signature: _____ **Date:** _____

618 S. Peabody St. Ste A
Port Angeles, WA 98362
Office: 360-452-4615
Fax: 36-452-0764
Email: smiles@swensondentalclinic.com

AUTHORIZATION TO RELEASE HEATHCARE INFORMATION

Patient's Name: _____

Other family members: _____

Date of Birth: _____

Prior Office: _____

Phone: _____

Fax: _____

Email: _____

Last Prophy: _____ **Last Perio Maintenance:** _____

SCRP: _____ **Full Mouth Deb.** : _____

Pano/FMX: _____ **BWX:** _____ **PAX:** _____

I understand that my authorization will remain effective from the date of my signature and that the information will be handled confidentially in compliance with all applicable Federal Laws. I understand that I may see the information that is to be sent. I have read and understand the nature of this release.

Signature of Patient: _____

Relationship to patient if not self: _____