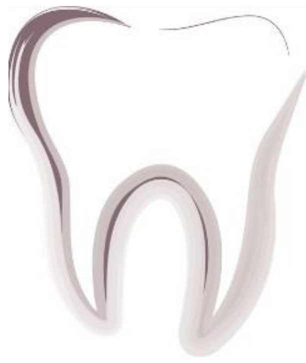

Mill Creek
dental health care

Natasha Habib DDS, PS & Linda Cirtaut DDS, PS

New Patient Pre-Appointment Check-List

Welcome to our practice. We want to make sure your first visit to our office is an exceptional one. To help us meet your expectations please use this check-list to make sure we have all of the information we'll need for your visit.

- **Contact your previous dentist and ask them to send your records to:**

  office@mcdhc.com

- **Complete new patient forms before you arrive and bring them with you to your appointment. You can fill the forms electronically but please print them out and bring with you.**
- **Arrive 10 minutes before scheduled time for paperwork**
- **Bring your insurance card if one was issued**
- **Bring your driver's license or other government issued photo ID**
- **If you are a dependent on an insurance plan please have:**
  - **Insured's Name, Address & Phone Number**
  - **Insured's Date of Birth**
  - **Insured's Plan, Member ID# or SSN**
  - **Insurance Group Number**
  - **Insured's Employer**
  - **Insured's Date of Birth**
- **Have a list of all medications you are currently taking**
- **Take any pre-medications required by your physician**

We look forward to meeting you!

Natasha Habib, DDS & Linda Cirtaut, DDS and Team

1025 153rd St. SE | Suite 103 | Mill Creek WA 98012 | 425.745.2703 | office@mcdhc.com

Patient Registration

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Patient Information:

Patient Name ______________________ Birthdate __________ Social Security # __________

What do you prefer to be called ______________________

Address ________________________________ City __________ ST_____ Zip __________

Home Phone __________ Cell Phone __________ Work Phone __________

Email ________________________________

Gender: ☐Male ☐Female Marital Status: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed

Employer ______________________ Occupation ______________________

If Student, Name of School ______________________

Spouse/Partner Name __________________ Spouse Partner Birthdate __________________

Spouse/Partner Phone __________________ Spouse/Partner Employer __________________

Please check all the ways you heard about our office:

☐Friend/Family ☐Google ☐Facebook ☐Insurance ☐Print Ad ☐Staff

If a friend or family member referred you, we would like to thank them. To whom may we send our thanks? ________________________________

If Patient is a minor, please complete the following:

Name of person responsible for this account _______________ Relationship to Patient __________

Birthdate __________ Social Security # __________

Address ________________________________ City __________ ST_____ Zip __________

Home Phone __________ Cell Phone __________ Work Phone __________

Email ________________________________

Employer ______________________ Occupation ______________________

General Information:

Patient's Previous Dentist ____________________ Phone ______________________

Patient's Orthodontist ____________________ Phone ______________________

Other people involved in dental care ____

Patient's Physician ____________________ Phone ______________________

Emergency Contact ____________________ Phone ______________________

Insurance Information:

Primary Coverage:	
Insurance Company	
Claims Address	
Policy Holder	
Birthdate	
Social Security #	
Employer Group#	

Secondary Coverage:	
Insurance Company	
Claims Address	
Policy Holder	
Birthdate	
Social Security #	
Employer Group#	

Medical/Dental History Questionnaire

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Please list all: (use back if need)

Medications and Supplements:

Allergies/Sympotoms:

Current Health Conditions:

Do you have or have you had any of the following:

Condition	Yes / No
Heart problems	☐ Yes ☐ No
High Blood Pressure	☐ Yes ☐ No
Low Blood Pressure	☐ Yes ☐ No
Pacemaker	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No
Joint Replacement	☐ Yes ☐ No
Is pre-medication required before dental treatment? If so, what type/dosage:	☐ Yes ☐ No
HPV	☐ Yes ☐ No
Cancer	☐ Yes ☐ No
Tumors	☐ Yes ☐ No
Radiation	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No
Gum Surgery	☐ Yes ☐ No
Scaling and Root Planing (Deep Cleaning)	☐ Yes ☐ No
Jaw Pain	☐ Yes ☐ No
Orthodontics (braces)	☐ Yes ☐ No
Easy bruising	☐ Yes ☐ No
Abnormal bleeding	☐ Yes ☐ No
Frequent nose bleeds	☐ Yes ☐ No
Anemia	☐ Yes ☐ No
History of blood transfusion	☐ Yes ☐ No
History of stroke or TIA	☐ Yes ☐ No
Sinusitis	☐ Yes ☐ No
Asthma	☐ Yes ☐ No
Tuberculosis	☐ Yes ☐ No
COPD	☐ Yes ☐ No
Hepatitis, type:	☐ Yes ☐ No
Liver problem	☐ Yes ☐ No
Kidney problem	☐ Yes ☐ No
Bladder problems	☐ Yes ☐ No
Gastric Ulcers	☐ Yes ☐ No
Mental/Emotional Disorder Explain:	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No
Back or Neck pain	☐ Yes ☐ No

Condition	Yes / No
Osteoporosis or Osteopenia	☐ Yes ☐ No
History of Fainting	☐ Yes ☐ No
History of Seizures	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No
History of head trauma	☐ Yes ☐ No
Frequent or severe headaches or migraines	☐ Yes ☐ No
Thyroid concerns	☐ Yes ☐ No
Diabetes Type: HbA1c:	☐ Yes ☐ No
Family history of diabetes	☐ Yes ☐ No
Excessive thirst	☐ Yes ☐ No
Dry mouth	☐ Yes ☐ No
Oral Herpes or cold sores	☐ Yes ☐ No
HIV + or Acquired Immune Deficiency Syndrome	☐ Yes ☐ No
Seasonal allergies	☐ Yes ☐ No
Do you smoke?	☐ Yes ☐ No
Do you use smokeless tobacco?	☐ Yes ☐ No
History of alcohol or drug abuse	☐ Yes ☐ No
Have you received an organ transplant?	☐ Yes ☐ No
Have you donated an organ for transplant?	☐ Yes ☐ No
Other disease not listed:	☐ Yes ☐ No

Do you take or have you taken any medications associated with osteoporosis or bone cancer? If so, were they given
☐ **orally or** ☐ **intravenously?** (please check one)

Women:
Are you pregnant? Due Date?
Are you nursing?
Contraceptives/other hormones:
Men:
Do you take medications for erectile dysfunction?
Do you have history of prostate cancer?

Other comments:

Dental History:

What is the reason for today visit?

Are you currently experiencing any dental pain or discomfort? □Yes □No
If Yes, where? Upper Left Upper Front Upper Right Lower Left Lower Front Lower Right
Is the pain associated with? Biting Sweets Cold Heat Air
Are you taking any medications for this pain? Yes No
If Yes, please list the medication/dosage:

When was your last dental exam/cleaning?
How often do you have your teeth cleaned?
Do you brush your teeth at least twice a day? □Yes □No
Do you floss at least once a day? □Yes □No
Do your gums bleed when you floss or brush? □Yes □No
Have you ever been diagnosed with periodontitis or peridontal disease? □Yes □No
Does food become lodged between teeth? □Yes □No
Do you avoid brushing or flossing due to pain? □Yes □No
Have you ever noticed slow healing sores in your mouth? □Yes □No
Does your breath concern you? □Yes □No

Do you have difficulty chewing your food? □Yes □No
Do you avoid chewing due to pain? □Yes □No
Does your jaw hurt when you chew or open it wide to take a bite? □Yes □No
Do you clench or grind your teeth or have any jaw issues? □Yes □No
Do you wear any type of retainer, night-guard or removable oral appliance? □Yes □No
If yes, please describe:

Are you apprehensive about dental treatment? □Yes □No
Have you used anti-anxiety medication or Nitrous Oxide (Laughing Gas) for dental visits? □Yes □No
If Yes, please describe:

Do you smoke or chew tobacco? □Yes □No
If Yes, how often?
Do you drink alcohol? □Yes □No
If Yes, how often?

What are your oral health goals?

What would you change about your smile?

Are you interested in whitening your teeth? □Yes □No

I understand that the information I have provided on these forms 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 necessary, you have my permission to request that information from the respective health care provider and for them to release to you. I will notify the doctor of any change in my health or medications.

Signature of Patient/Parent if Under 18/Guardian   Date

Print Name

Financial Policies and Acknowledgements

Mill Creek dental health care

Natasha Habib DDS, PS & Linda Cirtaut DDS, PS

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Financial Policies:

INSURANCE: Your insurance policy is a contract between you and your insurance company. As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We can estimate and will assist you in determining your insurance benefits. Any percentage not covered by your insurance is **due at the time services are rendered**. If for any reason the estimated amount is not paid by your insurance company, you will be responsible for the remaining balance. A 1% interest fee (max of 12% per annum) will be assessed to balances 60 days past due. **Initial** ____________

If your insurance policy has provisions such as deductibles, co-insurances, or co-payment please note that these are provisions that have been agreed to between you and your carrier. We cannot legally discount fees after their submission on your behalf to your carrier.

If we are networked with your carrier, we have an additional contractual obligation to collect the balances as outlined by your carrier. Writing off patient responsibility balances could jeopardize our contract with your carrier.

We sincerely regret if any of these regulatory provisions cause you an inconvenience, but we must be bound by all provisions of insurance policy and federal law.

NON-INSURED SERVICES and EMERGENCY SERVICES: Payment in full is required at time of treatment. We fully believe dental treatment is an excellent investment in an individual's wellbeing. Financial concerns should not be an obstacle to obtaining this important service. We offer multiple payment options to accommodate your needs as best we can.

PAYMENT OPTIONS

- **Credit Card** – VISA/MasterCard
- **Lending Club** – Independent financial institution
- **In-house Financing** – On a case by case basis

I hereby authorize my insurance benefits to be paid directly to the dentist. I understand that I am financially responsible for any balances due. I authorize the dentist to release any information required for my dental claims.

I certify that I have read and understand the contents of this form.

PRINTED NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

PATIENT CANCELLATION/MISSED APPOINTMENT AGREEMENT

Trying to accommodate every patient's individual needs and work schedules can be difficult, but we always try our best. We work very hard to stay on schedule so that our valuable patients will not spend time in our reception area waiting for their appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time just for you. When appointments are missed or cancelled, that time is permanently lost.

We ask when you schedule an appointment that you make every effort to keep that commitment. If you find that you cannot keep your scheduled appointment, we request that you provide a **minimum** notice of **48 business hours**. This time allows us to schedule another patient in need of treatment. Failure to do so may result in a **$75 per hour** late cancellation/missed appointment fee. We are closed on the weekend, so Monday cancellations must be made prior to Friday. We understand that personal emergencies sometimes occur and we always take that into consideration when receiving a last minute cancellation. We do not accept cancellation via text, email or voicemail. **Initial** ____________

If you have any questions, please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

PRINTED NAME: ______________________________

SIGNATURE: ______________________________

DATE: ______________________________

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the statement of Privacy Practices for the offices of Mill Creek Dental Healthcare. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Mill Creek Dental Healthcare reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION	
In addition to the allowable disclosures described in the Statement of Privacy Practices. I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)	
Spouse only	☐YES ☐NO
OR	
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐YES ☐NO
Any Member of my extended family: (Parents, Grandchildren)	☐YES ☐NO
Other:	☐YES ☐NO
Name of patient (Please print):	
Patient signature:	
Name of patient (Please print):	
Patient's personal representative: (Please Print):	
Representative's Telephone Number:	**Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained	
Provided Prior to Treatment? ☐YES ☐NO	Date Statement Provided:
Reason for not obtaining patient signature:	☐ Needed more time to review Statement
	☐ Wanted to consult another person before signing
	☐ Physically unable to sign
	☐ No reason offered
	☐ Other:

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North

527

LA Fitness

151st St SE

Main St.

Mill Creek Town Center

Mill Creek
dental health care

Schmidt Medical Center

153rd St SE

Snohomish County Fire Station 76

Central Market

Bothell Everett Hwy

Mill Creek Blvd

To I5

To I405

Directions from Dr. Habibs previous office

Head north on 62nd Ave W toward Olympic View Dr

Turn right onto 168th Street SW

Use the left 2 lanes to turn left onto 44th Ave W

Continue onto 164th St SW

Turn left onto WA-527 N

Turn Right onto 153rd St SE

Entrance is on the North side of the building

Directions to Mill Creek Dental Health Care

We're located at 1025 153rd St. SE.

At the intersection of Bothell-Everett Highway and 153rd St. SE. Look for us in the Schmidt Medical Center.

Entrance is on the North side of the building.

Need directions? Call us at 425-745-2703 or 425-743-4674

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