



Welcome to Yakima Smiles!

We are honored that you have selected Yakima Smiles as your dental home and will do everything possible to be worthy of the trust you have placed in us.

We are committed to providing you with the highest quality dental care in the most gentle, efficient and enthusiastic manner possible. We pride ourselves in our hundreds of five star reviews! Our primary goal is the retention of your healthy, natural teeth. We offer dentistry for kids of all ages, sleep apnea treatment, sedation dentistry, 6 Month Smiles Orthodontics and Face Focused Orthodontic Intervention. We have overhead TVs, nitrous oxide, warm blankets and the friendliest team in Yakima (and beyond!).

During your first visit, a comprehensive exam will be completed and Dr. Pete Nathe will provide you with treatment recommendations and options. There are many levels of dental health and we respect your right to choose what is best for you. We offer in house flexible financing to make treatment affordable.

We appreciate the value of your time, and except for emergency situations, you can expect us to be on time for you. We appreciate the same courtesy. We expect at least 48 hours advance notice for appointment cancellations to allow us to fill the opening in our schedule with another patient.

Please fill out the new patient forms and submit or print and bring with you to your appointment. Alternately, arrive 15 minutes early to fill out forms at our office.

Please call our office with any questions or visit our website at www.yakimasmls.com.

We are excited to meet you and are ready to assist you in achieving your dental health goals.

Dr. Pete Nathe and the team at Yakima Smiles

PATIENT MEDICAL HISTORY

Patient's Name:

For Office Use Only

ID:

Address:

Today's Date:

Date of Last Visit:

Date of Med. History:

City State Zip:

Email:

Home Phone:

Work Phone:

Cell Phone:

Birth Date:

Social Security No.:

Marital Status:

Primary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Secondary Dental Guarantor:

Home Phone:

Work Phone:

Cell Phone:

Physician Name:

Physician Phone:

Pharmacy:

Pharmacy Phone:

For Office Use Only

Medical Alerts:

Sex:

If female please answer the following:

Y N

☐ ☐ Are you taking Birth Control Pills?

☐ ☐ Are you pregnant?

If Yes, # of weeks

☐ ☐ Are you nursing?

Please answer the following:

Y N

☐ ☐ Do you smoke or use tobacco?

Height:

For Office Use Only

BP

Heart Rate:

Weight:

Y N **Conditions**

- ☐ ☐ Abnormal Bleeding
- ☐ ☐ Acid Reflux
- ☐ ☐ Alcohol Abuse
- ☐ ☐ Allergy To Any Meds
- ☐ ☐ Anemia
- ☐ ☐ Artificial Heart Valve
- ☐ ☐ Artificial Joints
- ☐ ☐ Asthma
- ☐ ☐ Bacterial Endocarditis
- ☐ ☐ Cancer- Chemotherapy
- ☐ ☐ Cardiovascular Problems
- ☐ ☐ Colitis
- ☐ ☐ Congenital Heart Defect
- ☐ ☐ Diabetes
- ☐ ☐ Difficulty Breathing
- ☐ ☐ Difficulty Getting Numb
- ☐ ☐ Drug Abuse
- ☐ ☐ Emphysema
- ☐ ☐ Epilepsy
- ☐ ☐ Fainting Spells
- ☐ ☐ Glaucoma
- ☐ ☐ HIV+ AIDS

Y N **Conditions**

- ☐ ☐ Hay Fever
- ☐ ☐ Headaches- Frequent
- ☐ ☐ Heart Attack
- ☐ ☐ Heart Murmur
- ☐ ☐ Heart Surgery
- ☐ ☐ Hemophilia
- ☐ ☐ Hepatitis
- ☐ ☐ Herpes
- ☐ ☐ High Blood Pressure
- ☐ ☐ Hospitalization
- ☐ ☐ Immune Disorders
- ☐ ☐ Jaw Joint Problems
- ☐ ☐ Kidney Problems
- ☐ ☐ Liver Disease
- ☐ ☐ Mitral Valve Prolapse
- ☐ ☐ Pace Maker
- ☐ ☐ Psychiatric Problems
- ☐ ☐ Radiation Therapy
- ☐ ☐ Seizures
- ☐ ☐ Sinus Problems
- ☐ ☐ Sleep Breathing Disorders
- ☐ ☐ Steroid Therapy

Y N **Conditions**

- ☐ ☐ Stroke
- ☐ ☐ Thyroid Problems
- ☐ ☐
- ☐ ☐
- ☐ ☐

Y N **Allergies**

- ☐ ☐ Aspirin
- ☐ ☐ Codeine
- ☐ ☐ Dental Anesthetics
- ☐ ☐ Erythromycin
- ☐ ☐ Jewelry
- ☐ ☐ Latex
- ☐ ☐ Metals
- ☐ ☐ Penicillin
- ☐ ☐ Tetracycline

Other

Medications:

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Y N

☐ ☐ Is there any disease, condition, or problem that you think this office should know about that is not covered above?
If yes, please describe below...

Notes:

Signature: _____ Date: _____
(If Under 18, Parent or Guardian Signature Required)

WELCOME
PATIENT INFORMATION

Name _____ Ph: Home _____ Work _____ Cell _____
Last First Initial

RESPONSIBLE PARTY

Person Responsible for Account _____
Last First Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different than patient) _____ Home Phone _____

City _____ State _____ Zip _____

Work Phone _____ Cell _____ E-mail _____

PRIMARY INSURANCE (if applicable)

Subscriber _____
Last First Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Employed by _____ Insurance Co _____ Group # _____

ADDITIONAL INSURANCE (if patient is covered by another insurance)

Subscriber _____
Last First Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Employed by _____ Insurance Co _____ Group # _____

- ☐ I am interested in payment options to finance any dental treatment I might need (OAC)
- ☐ I prefer to pay my estimated portion for dental treatment on the day of service.

SPOUSES' INFORMATION (if applicable)

Name _____

Home Phone _____

EMERGENCY INFORMATION (Relative not living with you)

Name _____

Home Phone _____

CONSENT

I understand that my dental insurance is a contract between me & my insurance carrier, and **not** between the insurance carrier and the Doctor and that I am fully responsible for all dental fees. These fees are due and payable at the time services are rendered unless prior written financial arrangements have been made. I also assign all insurance benefits to the Doctor. Any payments received by the Doctor from my insurance company will be credited to my account, or refunded to me if I have paid the dental fees incurred. I further understand that a 1.5% finance charge will be added to balances after 120 days (OAC). I am also aware of the firm 24 hour appointment policy.

Responsible Party _____ Date _____

I understand that where appropriate, credit reports may be obtained.

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I received a copy of the statement of privacy practices for the offices of Yakima Smiles. 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 operation. The statement of privacy practices also describes my rights and the responsibilities and duties of this office with respect to my health information. The statement of privacy practices is also posted in the facility.

Yakima Smiles reserves the right to change the privacy practices that are described in a 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 obtain a revised statement of privacy practices by requesting that one be mailed to me.

Additional Disclosure Authority

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 persons indicated below:

Any of my immediate family _____
Spouse only _____
Other (please specify) _____

Name of patient or personal representative

Signature of patient or personal representative

Date

Description of personal representative's authority

Office use below this line

Record of Acknowledgement not obtained

Provided prior to treatment? _____ Yes _____ No

Date provided: _____

Reason for denial: _____ Needed more time to review statement of privacy practices
_____ Wanted to consult with another person before signing
_____ Unable to sign
_____ Reason not given