Getting to know you as our patient:

PATIENT NAME:_____ **DATE OF BIRTH:**_____

PHONE:_____ **SOCIAL SECURITY#:**_____

ADDRESS:_____, _____, _____

Marital Status ❑ Single ❑ Married ❑ Divorced **Spouse's Name:** _____

Insurance Company Name: _____ ID#_____

Male ____ Female ____

How did you hear about our Office?

❑Phone Book ❑Relative/Friend ❑Internet ❑Doctor ❑Flyer ❑Sign by building
❑Other_____

Why have you come in to see us today?_____

Primary Dentist _____ Date of last cleaning/check up_____

Where did you get your current Denture or Partial_____

What do you like about it?_____

What do you wish were different about it?_____

How long have you had it?_____ How many have you had?_____

How often do you reline? _____ Last reline?_____

Adhesive use?_____ How often?_____

Y N Mental or Emotional Distress? ❑Bipolar ❑Depression ❑Anxiety ❑PTSD

❑Schizophrenia ❑Dementia ❑ Other _____

Y N Do you have Provider One DSHS or ANY insurance?_____

Y N I clench or grind my teeth during the day or while sleeping?

Y N My gums feel tender or swollen.

Y N My gums bleed while brushing or flossing.

Y N I have problems eating.

Y N I have had a facial or jaw injury

Y N Heart Disease

Y N Liver Disease

Y N Stroke Speech or facial muscles Affected? (what side) _____

Y N Hepatitis (Type)_____

Y N Diabetes

Y N Dry Mouth or excessive thirst

Y N Abnormal Blood Pressure

Y N Anemia

Y N Herpes

Y N Prolonged Bleeding Disorder

Y N Arthritis

Y N AIDS or HIV

Y N Tuberculosis or Lung Disease

Y N Sexually Transmitted/Venereal Disease

Y N Immune Suppressed Disorder

Y N Asthma

Y N Kidney Disease

Y N Hearing Loss

Y N Tumor or Malignancy

Y N Fainting Spells

Y N Sinus Trouble

Y N Cancer/Chemotherapy

Y N Epilepsy/Seizures

Y N Radiation Treatment

Y N Use of Tobacco products. What kind and for how many years? _____

Y N Allergic to any medications? _____

Y N Sensative to or Allergic to any Latex, Metals, or Plastics?

Y N Take Aspirin regularly?

Y N Take Ibuprofen regularly?

In the event of an emergency please contact:

Name :_____Relationship:_____ Phone:_____

Please list any medications: _____

_____

Patient's Signature _____Date_____

Treatment Consent & Office Policies Document

- **I UNDERSTAND THAT BY LAW I AM REQUIRED TO INFORM DENTURE ESSENTIALS OF ANY INSURANCE COVERAGE OF ANY KIND** _____ Patient Initials
- If you have to **reschedule your appointment for any reason** we ask that you notify us by **phone or email within 24 hours** to your scheduled appointment. There will be a charge for any missed appointments or appointments not cancelled 24 hours before the appointment.
- This office depends upon reimbursement from the patient for the costs incurred in their case. I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment.
- Payment policy is **half down to start treatment**, and order all necessary materials, such as teeth, **and the second half is due upon completion** and delivery of the appliance.
- No appliance may be released or delivered if not paid in full.
- Patient noncompliance and/or misconduct including and not limited to yelling, cursing, and threats will not be tolerated and will result in immediate dismissal of that patient.
- For relines, adjustments, and repairs, payment is due when services are rendered.
- I understand this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account, but, this office cannot render services on the assumption that charges will be paid by an insurance company, payments are ultimately the patient's responsibility.
- Remakes are offered **for reasonable fit and function reasons for free one time if deemed necessary**. Any other remake will incur a remake fee according to what changes are being requested. After that we may elect to grant a refund however basic materials used, services such as exam fee, and specialty materials used are deducted from available refund. **Refunds will not be permitted after 1 year of appliance delivery date.**
- **Wax Try In**
    1) A Wax Try In is a critical tool or the clinician and the patient to ensure that any appliance made is of good standard and to ensure our patients satisfaction.
    2) Unless the Wax Try In is waived by the clinician, it is mandatory and approval must be signed by the patient. Noncompliance of the signed esthetic approval form will result in patient dismissal. Any refund given will be less the materials used up until that point.
    3) Once permission has been given to finalize the appliance, refunds can be made in full up until changing the appliance from wax to plastic; however, **once wax is made into plastic a minimum of $500 per arch is non-refundable** due to material loss for all materials used up to that point.
- Adjustments are free for any new appliance for the first 60 days, after which, an adjustment fee applies.
- **Concerning the Alteration of an appliance not originally made by Denture Essentials**, the terms on the "Release and Consent to Adjust Elsewhere Denture" apply in full.
- **Warrantee and guarantee** of appliances made at denture essentials but altered by another person or practice other than Denture Essentials will automatically be void, and responsibility transferred to party who made the alterations.
- **Even though the utmost care and diligence is exercised in preparation and fabrication of prosthetic appliances, there is a possibility of failure with patients not adapting to the new dentures.** I understand that the process of fabricating and fitting removable prosthetic appliances (Partials and/or Dentures) includes risks and possible failures. I agree to assume those risks and possible failures associated with but not limited to the following:
    1. **Dentures and Immediate Dentures**: There are many variables which may contribute to a failure possibility such as:
        1) Gum tissues which cannot bear the pressures placed upon them resulting in excessive tenderness or sore spots, especially during the healing process following extraction and denture placement
        2) Ridges that are mobile or atrophied or have bone protuberances may not provide adequate support and/or retention as shrinkage occurs following extractions
        3) Musculature in the tongue, floor of the mouth, cheeks, etc., which may not adapt to and be able to accommodate the new artificial appliances
        4) Sensitive gag reflex, or speech difficulty as the mouth adapts to the new dentures

5) Excessive saliva or excessive dryness of mouth
6) General psychological and/or physical problems interfering with success

2. **Removable Partial Dentures**: Many variables may contribute to the unsuccessful utilizing of partial dentures (removable bridges). The variables may include those problems related to failure of complete dentures in addition to:
    1) Natural teeth to which partial dentures are anchored (called abutment teeth) may become tender, sore and/or mobile as support of the ridge changes during healing
    2) Abutment teeth may decay or erode around the clasps or attachments
    3) Tissues supporting the abutment teeth may fail after healing is complete
3. **Breakage**: Due to the types of materials which are necessary in the construction of these appliances, breakage may occur even though the materials used were not defective. Factors which may contribute to breakage are:
    1) Chewing on foods or objects which are excessively hard
    2) Gum tissue shrinkage which causes excessive pressures to be exerted unevenly on the dentures, especially as the tissues heal and change
    3) Cracks which may be unnoticeable and which occurred previously from causes such as those mentioned in (1) and (2)
    4) Use of porcelain teeth as part of the denture, or the dentures having been dropped or damaged previously in the event of the denture reline. The above factors listed may also cause extensive denture tooth wear or chipping
4. **Loose Dentures**: Immediate complete dentures normally become less secure over the initial months as healing progresses and the ridge changes. Dentures themselves do not change unless subjected to extreme heat or dryness. After several months once healing is complete, the dentures will generally be quite loose and a reline or even rebase (replacement of all tissue colored material supporting the teeth) will become necessary. During the healing process some chairside relines may be performed, but eventually a laboratory processed reline or rebase will be necessary. It will be necessary to charge a fee for relining or rebasing dentures and I understand that the fee for immediate dentures does not cover this reline or rebase fee. Immediate partial dentures may become loose for the same reasons listed.
5. **Allergies to denture materials**: Infrequently, the oral tissues may exhibit allergic symptoms to the materials used in construction of either partial dentures or full dentures.
6. **Failure of supporting teeth and/or soft tissues.** Natural teeth supporting immediate partial dentures may fail due to decay; excessive trauma; gum tissue or bony tissue problems. This may necessitate extraction. The supporting soft tissues may fail due to many problems including poor dental or general health.
7. **Uncomfortable or strange feeling**: This may occur because of the differences between natural teeth and the artificial dentures. Most patients usually become accustomed to this feeling in time. However, some patients have great difficulty adapting to complete dentures.
8. **Esthetics or appearance**: Patients will be given the opportunity to observe the anticipated appearance of the dentures prior to processing. If satisfactory, this face will be acknowledged by the patient's signature (or signature of legal guardian) on this form where indicated.
9. **It is the patient's responsibility to seek attention when problems occur and do not lessen in a reasonable amount of time; also, to be examined regularly to evaluate the tissue response to the dentures during healing, condition of the gums, and the patient's oral health.**

_____

Please Print Name

Signed_____**Date**_____

DENTURE

Essentials

HIPPA PATIENT CONSENT FORM

The Department of Health and Human Services has established a “Privacy Rule” to help ensure the personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patient’s consent for uses and disclosures of health information about the patient, to carry out treatment, payment, or health care operations.

As our patient, we want you to know that we respect the privacy of your personal dental records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations. In order to provide health care that is in your best interest.

We also want you to know that we support our full access to your personal dental records as provided by the Washington State Code. We may have indirect treatment relationships with you (such as laboratories that only interact with doctors and not patients) and may have to disclose personal health information for purposes of treatment, payment or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you, should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in the document, at some future time, you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken, which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent, in writing, after you have reviewed our privacy notice.

_____ _____

Print Patient/Parent/Guardian’s Name Signature

_____ _____

Witness Signature Date

For Office Use Only

_____ Patient refused to sign. Reason: _____

Employee Signature: _____

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