MEDICAL HISTORY

NAME: _____

BIRTHDATE: _____ **HEIGHT:** _____ **WEIGHT:** _____

ARE YOU CURRENTLY BEING TREATED BY A PHYSICIAN? _____ **IF SO, WHO?**

PHYSICIAN: **Dr.** _____ **PHONE #:** _____

ADDRESS: _____

DATE OF LAST EXAM: _____ **RESULTS/FINDINGS:** _____

WHAT IS YOUR ESTIMATION OF YOUR GENERAL HEALTH: EXCELLENT _____ **GOOD** _____ **FAIR** _____ **POOR** _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS, OR HAVE YOU IN THE PAST YEAR? _____

IF SO, WHAT? _____

HAS THERE BEEN ANY CHANGE IN YOUR GENERAL HEALTH IN THE PAST YEAR? _____

IF SO, WHAT? _____

DO YOU OR HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS?

(CIRCLE IF YES)

Any serious illness
Hospitalized for illness or surgery
Hepatitis, Jaundice, or Liver Disease
Acquired Immune Deficiency Syndrome (AIDS)
Diabetes
Blood relatives with Diabetes
Heart Trouble
Rheumatic Fever/Rheumatic Heart Disease
High Blood Pressure
Chest pains or shortness of breath
Stroke
Allergies
Hives, Rash, or Hay Fever
Sinus Problems
Emphysema
Tuberculosis
Epilepsy, Seizures, or Fainting Spells
Frequent Headaches
Facial Trauma
Asthma
Hip/Joint Replacement
Bisphosphnates (Boniva, Fosamax etc.)

Blood Disorders
Bleeding Problems
Anemia
Tumor or Growth
ADVERSE DRUG REACTIONS TO:
- **Aspirin**
- **Penicillin**
- **Erythromycin**
- **Sulfa**
- **Tetracycline**
- **Codeine**
- **Dental Anesthetic**
- **Nitrous Oxide**
- **Sedative**
- **Sleeping Pills**
- **Alcoholism**
- **Drug Habits**

WOMEN ARE YOU CURRENTLY:
- **Pregnant**
- **Taking Birth Control Pills**

ANY OTHER COMMENTS ON YOUR GENERAL HEALTH OR HEALTH HISTORY? _____

SIGNATURE: _____ **DATE:** _____

PATIENT INFORMATION

NOTE: Dr. Erickson is a participating doctor with Washington Dental Service and Regence only. He is not a preferred provider for any other

TITLE: _____ FULL NAME: _____ NICKNAME: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

STREET ADDRESS (If Different from Above): _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ SOCIAL SECURITY It: _____

HOME #: _____ CELL #: _____ WORK #: _____

E-Mail : _____

EMPLOYER NAME/ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SPOUSE'S NAME: _____ SPOUSE'S PRIMARY PHONE: _____

SPOUSE'S BIRTHDATE: _____ SPOUSE'S SOCIAL SECURITY #: _____

SPOUSE'S EMPLOYER: _____ WORK #: _____

Emergency contact number #

REFERRING DOCTOR: _____ PHONE: _____

PRIMARY INSURANCE

INSURANCE COMPANY: _____

IF DIFFERENT THAN ABOVE
SUBSCRIBER'S NAME: _____

SUBSCRIBER ID #: _____

SUBSCRIBER BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____

GROUP #: _____

EMPLOYER: _____

ADDRESS: _____

SECONDARY INSURANCE

INSURANCE COMPANY: _____

SUBSCRIBER'S NAME: _____

SUBSCRIBER ID #: _____

SUBSCRIBER BIRTHDATE: _____

RELATIONSHIP TO PATIENT: _____

GROUP #: _____

EMPLOYER: _____

ADDRESS: _____

PERSON RESPONSIBLE FOR PAYMENT (Must be 18 or Over): _____ PHONE: _____

MAILING ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

STREET ADDRESS (If Different from Above): _____ CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ SOCIAL SECURITY #: _____ DRIVERS LICENSE: _____

EMPLOYER: _____ PHONE: _____

ASSIGNMENT AND RELEASE: I hereby authorize my insurance benefits be paid directly to the Doctor. I understand that I am responsible for all costs of medical treatment. Although Dr. Erickson staff will assist me in filing my insurance claim, I am personally responsible for knowing my dental insurance benefits and limits. I also authorize the Doctor or insurance company to release any information required for this claim. I hereby authorize my Doctor's office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper medical cam I certify that all of the above information is correct and I have read and will subscribe to the Financial Policy on the next form.

SIGNATURE: _____ DATE: _____

Sky Ridge Periodontics & Implants
Graig Erickson, DDS, MSD

Diplomate of the American Board of Periodontology

INFORMATION ABOUT YOUR MEDICAL/DENTAL SERVICE

We feel strongly that our patients deserve the best care. In an effort to provide high quality care, we would like to share information with you about financing healthcare. We hope that by providing you with the following information, we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us.

I. We ask that you pay in full at your first visit. If you have insurance, please pay that portion which insurance does not cover.

II. We accept VISA, Mastercard, American Express, Discover and CareCredit Cards.

III. Remember that, if you have insurance, the insurance contract is between the patient and the insurance company. The patient is responsible for all account balances, even with insurance benefits. We will bill your insurance as a courtesy to you, but we cannot guarantee your benefits. We will only bill those insurance companies for which you provide WRITTEN information to us prior to the treatment given. If your insurance provider informs us of benefits that you are entitled to, we will advise you of same. Any oral representation we make in good faith to you concerning your insurance is not binding on us and will not in any way or for any reason be considered a modification of this writing.

IV. This information sheet is the full and final agreement between this office and you regarding your insurance and benefits and may not be modified without a WRITTEN agreement signed by you and this office.

V. Within 30 days of service, the balance should be paid in full. Interest will be charged at 18% per year (1.5% per month) on balances over 90 days past due.

VI. Many insurance plans cover a certain percentage of the fees. Normally the insurance company will cover the "usual and customary fees." These benefits are determined normally by how much your employer paid for the plan. Your insurance, as a result, may cover less than you thought they might have. Please be familiar with the benefits provided by your plan.

VII. The age of majority in this state is 18 years old. The parent that brings in the minor child is responsible for payment.

VIII. Past due accounts will be sent to a collection agency at our discretion. We charge $25.00 for checks returned due to insufficient funds.

IX. Your appointment is reserved exclusively for you. All surgery cancellations without seven days notice are subject to a $100 cancellation fee. All other appointments, without 48 hours notice, are subject to a $50.00 cancellation fee.

X. I understand credit information may be accessed in order to determine my credit worthiness. I understand that I am responsible for the entire balance of the account and that this office is extending credit to me.

I AUTHORIZE INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR PROVIDING MEDICAL/DENTAL CARE. I ALSO GIVE PERMISSION FOR THE DOCTOR TO RELEASE INFORMATION IN ORDER TO PROCESS THE CLAIM. I AGREE THAT I AM RESPONSIBLE FINANCIALLY FOR ALL BALANCES DUE.

_____ _____

Signature: Date:

_____

Printed Name:

Sky Ridge Periodontics & Implants
Graig Erickson, DDS, MSD

Diplomate of the American Board of Periodontology

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office(s) of Sky Ridge Periodontics. 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.

Sky Ridge Periodontics reserves the right to change the privacy practices that are 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 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 health care information to the persons indicated below.		
ANY MEMBER OF MY IMMEDIATE FAMILY	Yes ☐	No☐
SPOUSE ONLY	Yes ☐	No☐
OTHER (Please Specify)	Yes ☐	No☐

_____ _____

Name of the Patient or Personal Representative | Signature of Patient or personal Representative

_____ _____

Date | Description of Personal Representative's Authority