Jackie Snapp, DDS, PLLC
827 128th Street SW, Suite D
Everett, WA 98204
(425) 353-0110
info@snappdds.com

WELCOME TO SNAPP DENTAL!

We are looking forward to having you join our group of friends and patients. The benefits of a healthy, beautiful smile are immeasurable and our goal is to help you obtain the health teeth and attractive smile you want and deserve. Please complete these forms so that we can provide the best possible care for you.

Today's Date: _____

Name of patient: _____ Date of Birth_____

I prefer to be called: _____ Social Security #_____

Home Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____Mobile phone: _____

Work number: _____Best time to call: _____

Email address: _____

May we send you email courtesy reminders? **Y / N**

May we send you text message courtesy reminders? **Y / N**

Marital Status: _____Spouse's name: _____

Special interests or hobbies: _____

Do we see other family members? _____

Whom can we thank for referring you? _____

Nearest relative that's not living with you or in case of emergency who can we call?

Name: _____ Relationship: _____

Phone number: _____

Primary Insurance

Name and address:

_____
_____
_____
Phone number: _____
Employer: _____
_____
Subscriber Name (employee)

_____
Date of Birth: _____
Member ID#:_____
Group #:_____

Secondary Insurance

Name and address:

_____
_____
_____
Phone number: _____
Employer:

Subscriber Name (employee)

_____
Date of Birth: _____
Member ID#_____
Group #:_____

In consideration of the services rendered to me, or my dependents, I am obligated to pay Dr. Jackie Snapp in accordance with her credit terms and policies.

SIGNATURE: _____ DATE: _____
(Parent, if patient is a minor)

For our clients that have dental insurance, to help with a portion of their dental expenses, we will bill your insurance for you and accept payment directly from your insurance company to apply to your account with our office. T**he patient is responsible for the full fee charged regardless of insurance benefits**. Each insurance company and policy has unique limitations and their own schedule of dental benefits, which is dependent on what your employer has purchased for you. 1% per month fee on balances over 90 days.

"SIGNATURE ON FILE"
(FOR ASSIGNED DENTAL CLAIMS)

ASSIGNMENT:
I AUTHORIZE PAYMENT DIRECTLY TO THE DENTIST. A COPY OF THIS AUTHORIZTION AND ASSIGNMENT SHALL BE AS VALID AS THE ORIGINAL. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO MY DENTAL CLAIMS.
I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF DENTAL TREATMENT REGUARDLESS OF ANY THIRD PARTY BENEFIT.

SIGNATURE: _____ DATE: _____

Appointment Policy

A scheduled appointment is a commitment of time between the Doctor and patient. We reserved a set amount of time just for you. When appointments are missed or cancelled, that time is lost.

We ask that when you appoint for treatment, you make every effort to keeping that appointment. We understand that emergencies do arise, and we will take that into consideration. If you find that you cannot keep your scheduled appointment, our required 48-hour notice allows us to see another patient in need of treatment.

It is a policy of our office that missed appointments without a minimum of 48 hour notice will result in a charge being considered and applied to your account.

Thank you for your consideration and cooperation.

Jackie Snapp, DDS, PLLC

I have read and understand this policy.

Signed _____ Date _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING: **YES** **NO**

PERSONAL HISTORY

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [____] _____ ☐ ☐
2. Have you had an unfavorable dental experience? _____ ☐ ☐
3. Have you ever had complications from past dental treatment? _____ ☐ ☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____ ☐ ☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____ ☐ ☐
6. Have you had any teeth removed? _____ ☐ ☐

GUM AND BONE

7. Do your gums bleed or are they painful when brushing or flossing? _____ ☐ ☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____ ☐ ☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____ ☐ ☐
10. Is there anyone with a history of periodontal disease in your family? _____ ☐ ☐
11. Have you ever experienced gum recession? _____ ☐ ☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____ ☐ ☐
13. Have you experienced a burning sensation in your mouth? _____ ☐ ☐

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years? _____ ☐ ☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____ ☐ ☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____ ☐ ☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____ ☐ ☐
18. Do you have grooves or notches on your teeth near the gum line? _____ ☐ ☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____ ☐ ☐
20. Do you frequently get food caught between any teeth? _____ ☐ ☐

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____ ☐ ☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____ ☐ ☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____ ☐ ☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____ ☐ ☐
25. Are your teeth crowding or developing spaces? _____ ☐ ☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____ ☐ ☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____ ☐ ☐
28. Do you clench your teeth in the daytime or make them sore? _____ ☐ ☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____ ☐ ☐
30. Do you wear or have you ever worn a bite appliance? _____ ☐ ☐

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change? _____ ☐ ☐
32. Have you ever whitened (bleached) your teeth? _____ ☐ ☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____ ☐ ☐
34 Have you been disappointed with the appearance of previous dental work? _____ ☐ ☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____
Name of Physician/and their specialty _____
Most recent physical examination _____ Purpose _____
What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury_____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever_____	☐	☐
9. high or low blood pressure_____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox_____	☐	☐
15. asthma_____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c =_____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma_____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth_____	☐	☐
35. hives, skin rash, hay fever_____	☐	☐
36. STI / STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth_____	☐	☐
40. radiation therapy_____	☐	☐
41. chemotherapy, immunosuppressive_____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment_____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements_____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches_____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed_____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

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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 Jackie Snapp, DDS, PLLC. 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.

Jackie Snapp, DDS, PLLC 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 Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____
Date Description of Personal Representative's Authority

OFFICE USE ONLY 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.
	☐	OTHER (EXPLAIN):

OFFICE FINANCIAL POLICY

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In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payment.

- **Cash or Check**
- **Visa, MasterCard, Discover, American Express**
- **Care Credit (6 months Deferred Interest or 24 months fixed monthly payments)**

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any insurance that I may have. I understand that all services are due to be paid in full within ninety (90) days of the date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest (12% per year) will be charged on accounts 90 days from the treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

We are here to assist you in any way possible. Please make your questions and concerns known to our team… Our goal is to ensure that you have an outstanding experience. Thanks for giving us the opportunity to care for your dental needs.

_____

Signature (responsible party)
Date