



**DR. ANTONIO LOPEZ-IBARRA, DDS**  
FAMILY & COSMETIC DENTISTRY

(509) 933-3300

A DENTAL EXPERIENCE LIKE NO OTHER!

601 North Main Street,  
Ellensburg WA, 98926

**WELCOME TO OUR OFFICE ~ WE LOOK FORWARD TO GETTING TO KNOW YOU**

Date: \_\_\_\_\_ ☐ NEW PATIENT ☐ UPDATE

Patient: \_\_\_\_\_

LAST FIRST MI PREFERRED TITLE

☐ MALE ☐ FEMALE ☐ CHILD ☐ STUDENT ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Patient Date of Birth: \_\_\_\_\_ Patient SSN: \_\_\_\_\_

Address: \_\_\_\_\_

ADDRESS LINE 1

ADDRESS LINE 2

CITY ST ZIP CODE

HOME: \_\_\_\_\_

CELL: \_\_\_\_\_

TEXT \_\_\_\_\_

OK?: \_\_\_\_\_

E-Mail: \_\_\_\_\_

Referral? ☐ Yes ☐ No Whom may we thank for referring you: \_\_\_\_\_

**EMERGENCY CONTACT**

NAME RELATIONSHIP Tel: \_\_\_\_\_

**EMPLOYMENT INFORMATION**

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

**DENTAL HISTORY**

Previous Dentist/clinic: \_\_\_\_\_ Reason for change: \_\_\_\_\_

☐ Y ☐ N Are you currently having dental discomfort? If yes, explain: \_\_\_\_\_

☐ Y ☐ N Are your teeth sensitive? ☐ to cold ☐ to hot ☐ to sweets ☐ when biting

What factors are most important for your satisfaction with our office? \_\_\_\_\_

**ACKNOWLEDGEMENT OF PRIVACY PRACTICES (Updated 2015)**

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

☐ I give permission for the following communications to be used by Dr. Antonio Lopez-Ibarra (please check all that apply) :

☐ Cell phone: ☐ Text Message reminders permitted ☐ E-Mail: ☐ Home phone ☐ Work

☐ I am granting permission for Dr. Antonio Lopez-Ibarra to leave a message with any person who may answer my phone or on my voicemail of the following numbers (please check all that apply):

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ None- please just ask for a call back ☐ Other (Please explain)

I would like to give permission for the following person(s) to have access to personal information including but not limited to appointments, treatment, and billing of myself and any dependent children as well:

MEDICAL HISTORY	
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GENERAL HEALTH: ☐ EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR      PRIMARY PHYSICIAN:

- |   |  |       |
|---|--|-------|
| <input type="checkbox"/> Y <input type="checkbox"/> N | Under a physician's care now?  |       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any hospitalization in the past 5 years?   | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Any serious illnesses/surgeries?   | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Use tobacco in any form? If Yes, Type:   | _____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Is pre-medication required before dental visits due to heart condition or artificial joint?                    |       |
| <input type="checkbox"/> Y <input type="checkbox"/> N | Taking any prescription or daily OTC medications/drugs? <i>If yes, list details in the Medication Section.</i> |       |

FEMALE PATIENTS: ☐Y☐N Currently nursing? ☐Y☐N Currently pregnant? Due Date: \_\_\_\_\_

Do you know of any reason why routine dental procedures might pose a risk to you, our staff, or other patients? ☐Y☐N  
If yes, please describe:

Is there anything important about your medical condition we have not asked? ☐Y☐N If yes, please describe:

ALL PATIENTS: DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY): ☐ NONE

- |   |  |  |  |
|---|--|--|--|
| <input type="checkbox"/> ACID REFLUX            | <input type="checkbox"/> BULIMIA                 | <input type="checkbox"/> HEART ATTACK          | <input type="checkbox"/> PSYCHIATRIC TREATMENT |
| <input type="checkbox"/> ADHD                   | <input type="checkbox"/> CANCER/MALIGNANCY       | <input type="checkbox"/> HEART DISEASE         | <input type="checkbox"/> RADIATION/CHEMO       |
| <input type="checkbox"/> AIDS/HIV               | <input type="checkbox"/> CEREBRAL PALSY          | <input type="checkbox"/> HEART MURMUR          | <input type="checkbox"/> RESPIRATORY DISEASE   |
| <input type="checkbox"/> ANEMIA                 | <input type="checkbox"/> CHEMICAL DEPENDENCY     | <input type="checkbox"/> HEPATITIS             | <input type="checkbox"/> RHEUMATIC FEVER       |
| <input type="checkbox"/> ANOREXIA               | <input type="checkbox"/> CONVULSIONS             | <input type="checkbox"/> HIGH BLOOD PRESSURE   | <input type="checkbox"/> SINUS PROBLEMS        |
| <input type="checkbox"/> ANXIETY                | <input type="checkbox"/> DEPRESSION              | <input type="checkbox"/> KIDNEY DISEASE        | <input type="checkbox"/> STROKE                |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> DIABETES                | <input type="checkbox"/> LIVER PROBLEMS        | <input type="checkbox"/> THYROID CONDITION     |
| <input type="checkbox"/> ARTIFICIAL JOINTS      | <input type="checkbox"/> DIZZINESS/FAINTING      | <input type="checkbox"/> MITRAL VALVE PROLAPSE | <input type="checkbox"/> TUBERCULOSIS          |
| <input type="checkbox"/> ARTHRITIS              | <input type="checkbox"/> EPILEPSY/SEIZURES       | <input type="checkbox"/> MONONUCLEOSIS         | <input type="checkbox"/> ULCERS                |
| <input type="checkbox"/> ASTHMA                 | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> PACEMAKER             |  |
| <input type="checkbox"/> AUTISM/ASPERGER'S      | <input type="checkbox"/> FREQUENT HEADACHES      |  |  |
| <input type="checkbox"/> BLEEDING DISORDER      | <input type="checkbox"/> HEARING PROBLEMS        | <input type="checkbox"/> OTHER – PLEASE LIST:  |  |

ALL PATIENTS: ARE YOU ALLERGIC TO OR HAVE YOU EVER HAD ANY REACTION TO THE FOLLOWING? (CHECK ALL THAT APPLY):

- |   |                                  |   |   |                               |
|---|----------------------------------|---|---|-------------------------------|
| <input type="checkbox"/> ASPIRIN              | <input type="checkbox"/> CODEINE | <input type="checkbox"/> LACTOSE INTOLERANCE    | <input type="checkbox"/> SLEEPING PILLS               | <input type="checkbox"/> NONE |
| <input type="checkbox"/> ANESTHETIC – LOCAL   | <input type="checkbox"/> DAIRY   | <input type="checkbox"/> METAL SENSITIVITY      | <input type="checkbox"/> SULFA DRUGS                  |                               |
| <input type="checkbox"/> BARBITURATES         | <input type="checkbox"/> LATEX   | <input type="checkbox"/> NITROUS OXIDE SEDATION | <input type="checkbox"/> PENICILLIN/OTHER ANTIBIOTICS |                               |
| <input type="checkbox"/> OTHER – PLEASE LIST: |                                  |   |   |                               |

MEDICATION INFORMATION	
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ALL PATIENTS: ARE YOU CURRENTLY TAKING ANY OF THE FOLLOWING? (CHECK ALL THAT APPLY):	<input type="checkbox"/> NONE
--	-------------------------------

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> ANTIBIOTICS/SULFA DRUGS    | <input type="checkbox"/> ANTIHISTAMINES/ALLERGY   | <input type="checkbox"/> DAILY ASPIRIN       | <input type="checkbox"/> BLOOD PRESSURE MEDICATIONS |
| <input type="checkbox"/> BLOOD THINNERS             | <input type="checkbox"/> CANCER/CHEMO MEDICATIONS | <input type="checkbox"/> CORTISONE/STEROIDS  | <input type="checkbox"/> HEART MEDICATION/DIGITALIS |
| <input type="checkbox"/> INSULIN                    | <input type="checkbox"/> NITROGLYCERIN            | <input type="checkbox"/> ORAL CONTRACEPTIVES | <input type="checkbox"/> OSTEOPOROSIS MEDICATIONS   |
| <input type="checkbox"/> OTHER DIABETIC MEDICATIONS | <input type="checkbox"/> RECREATIONAL DRUGS       | <input type="checkbox"/> THYROID MEDICATIONS | <input type="checkbox"/> TRANQUILIZERS              |
| <input type="checkbox"/> OTHER (PLEASE LIST BELOW)  |   |  |   |

[illegible]



Central Washington  
DENTAL CARE

**DR. ANTONIO LOPEZ-IBARRA, DDS**

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## **Financial Guidelines**

*We are committed to providing you with the best care possible to achieve total oral health. In order to achieve these goals, we need your assistance and your understanding of our financial guidelines.*

### **Insurance**

**We accept all major dental insurance payments, however we may not be an in network provider for your plan.** If we are not an in network provider, review your plan details, as in many cases insurance reimbursement is very similar.

**We are in network for Delta Dental, Cigna, Aetna, Assurant, Premiera, United and many other insurances. We will gladly bill most insurances for you.**

**No estimate is a guarantee of payment.** Please understand, you are responsible for all charges not paid by your insurance. Also, many insurance companies are excluding certain dental procedures or downgrading procedures to a lesser reimbursement level; in which case, you would be responsible for the difference.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_ insurance and assign directly to Central Washington Dental Care all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I

Central Washington Dental Care may use my health care information and may disclose such information only to the above-named insurance company and their agents for the purpose of obtaining payment for services and

### **Payments**

- **As you know, dental insurance does not cover all the cost of your treatment. For your convenience, we offer the following payment options:**
  - o Cash, check, and all major credit cards are accepted (Visa, MasterCard, Discover)
  - o 5% Discount for our uninsured cash/check paying patients
  - o Care Credit Monthly Payment Plan (This is a line of credit which is used for health care expenses. Care credit offers low monthly payments and approval takes only a few minutes. We will gladly help you with the application. They have NO interest 6 or 12 month options.)
- **Balances left over 90 days will incur an 18% or \$10 minimum monthly finance charge.** We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

### **Short Cancelled/ Missed Appointments**

- **Please give 48 hours notice** if you are unable to keep your reserved time. Unless an emergency occurs, we expect to run on time for your appointments, and we appreciate the same courtesy from you.
- **Short canceled or missed appointments** will be charged \$50 per appointment.
- **By signing below I acknowledge I have read and understand the guidelines above.**

Signature:

Date: