

**Patient Registration**

Patient Name \_\_\_\_\_ Today's Date: \_\_\_\_\_

Mailing Address \_\_\_\_\_ Home Phone: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male Female

Marital Status: Single Married Widowed Divorced Spouses Name: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_

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

School: \_\_\_\_\_

Dentist: \_\_\_\_\_

How did you hear about our office? \_\_\_\_\_

Main Concern with your teeth or smile? \_\_\_\_\_

**Responsible Party**

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Marital Status: Single Married Widowed Divorced Spouses Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

Social Security: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_

Drivers License: \_\_\_\_\_ Custodial Parent: Yes No Other or N/A

Relationship to Patient: \_\_\_\_\_

**Dental Insurance Information**

INSURANCE PRIMARY: \_\_\_\_\_ INSURANCE SECONDARY: \_\_\_\_\_

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

Subscriber's Name: \_\_\_\_\_ Subscriber's Name: \_\_\_\_\_

ID# or SS# \_\_\_\_\_ ID# or SS# \_\_\_\_\_

DOB: \_\_\_\_\_ Group# \_\_\_\_\_ DOB: \_\_\_\_\_ Group# \_\_\_\_\_

I understand that the information that I have given is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes.

Patient Signature (parent if minor): \_\_\_\_\_ Date: \_\_\_\_\_

# HEALTH HISTORY QUESTIONNAIRE

Northwest Family Dental Care 27081 185<sup>TH</sup> Ave S.E. Covington, Washington 98042

<b>Name</b> <i>(Last, First, M.I.):</i>	<input type="checkbox"/> M	<input type="checkbox"/> F	<b>DOB:</b>
<b>Height:</b>	<b>Weight:</b>		

Are you in pain today? Where? Pain level 1-10?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you in good health?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has there been any change in your general health in the past year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you under physician's care for a particular problem?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had any serious illnesses, operations, or hospitalizations? If so, describe...	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When was your last physical exam?	When was your dental exam?	

<b>DO YOU HAVE OR HAVE YOU EVER HAD:</b>		
Rheumatic Fever or Rheumatic Heart Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease or Bacterial Endocarditis (SBE)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cardiovascular Disease (Heart Attack, Heart Trouble, Heart Murmur, Coronary Artery Disease, Angina, High Blood Pressure, Stroke, Palpitations, Heart Surgery, Pacemaker, High Cholesterol)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Lung Disease (Asthma, Emphysema, COPD, Chronic Cough, Bronchitis, Pneumonia, Tuberculosis, Shortness of Breath, Chest Pain, Severe Coughing)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Seizures, Convulsions, Epilepsy, Fainting, or Dizziness?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bleeding Disorder, Anemia, Hemophilia, Bleeding Tendency, Blood Transfusion? Do you bruise easily?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease (Jaundice, Hepatitis)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Disease?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Disease (Goiter)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stomach Ulcers or Colitis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Osteoporosis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Implants placed anywhere in your body (Heart Valve, Pacemaker, Hip, Knee)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Radiation (X-ray) treatment for Cancer?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Clicking or popping of jaw joint, pain near ear, difficulty opening mouth, grinding or clenching teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus or Nasal problems?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any disease, drug, or transplant operation that has depressed your immune system (i.e. - HIV/AIDS)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>ARE YOU USING ANY OF THE FOLLOWING?</b>		
Antibiotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anticoagulants (Blood Thinners)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin or drugs such as Motrin, Aleve, or Ibuprofen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High Blood Pressure medications?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Steroids (Cortisone, Prednisone, Anabolic, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tranquilizers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Insulin or Diabetic drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Digitalis, Inderal, Nitroglycerin or other heart drug?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you taking or have you ever taken Bisphosphonates for osteoporosis, multiple myeloma, or other cancers (Reclast, Fosamax, Actonel, Boniva, Aredia, Zometa, Prolia)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been advised to NOT take a medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**LIST ANY MEDICATIONS TAKEN, INCLUDING PRESCRIPTION, OVER THE COUNTER, VITAMINS OR MINERALS:**


**ARE YOU ALLERGIC TO OR HAVE YOU HAD AN ADVERSE REACTION TO:**

Local Anesthesia (Novocaine, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Penicillin or other antibiotics?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sedatives, Barbiturates, or Benzodiazepines?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Aspirin or Ibuprofen?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Codeine or other pain killers?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex or Rubber products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Metal of any kind?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemicals or jewelry (rash or sensitivity)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Food products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Please list any other allergies or reactions:		
Do you smoke or chew tobacco? If so, how much per day?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any history of Alcohol or Chemical Dependency?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any history of Emotional Disorders or Psychiatric Disorders that may affect the care we provide (i.e. - PTSD)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any serious problems associated with any previous dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you or an immediate family member had any problem associated with intravenous anesthesia?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any other disease, condition, or problem not listed above that you think the doctor should know about?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you wish to talk to the doctor privately about anything?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had a bone density scan?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**WOMEN ONLY**

Are you Pregnant, or is there any chance you might be Pregnant?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you nursing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<b>If you are taking Oral Contraceptives</b> , it is important that you understand that antibiotics (and some other medications) may interfere with the effectiveness of oral contraceptives. Therefore, you will need to use mechanical forms of birth control for one complete cycle of birth control pills after the course of antibiotics or other medication is completed. Please consult with your physician for further guidance.		

**MEN ONLY**

Are you taking vasodilators for Erectile Dysfunction (i.e.- Viagra, Cialis, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
---	------------------------------	-----------------------------

I understand the importance of a truthful and complete Health History to assist with my dentist in providing the best care possible. I have had the opportunity to discuss my Health History with my dentist. ANY QUESTIONS I HAD ABOUT THIS FORM HAVE BEEN ANSWERED AND I UNDERSTAND THE ANSWERS. I UNDERSTAND IT IS MY RESPONSIBILITY TO FILL OUT THE FORM CORRECTLY AND COMPLETELY.

<b>SIGNATURE:</b>	<b>DATE:</b>
-------------------	--------------

## **NORTHWEST FAMILY DENTAL CARE FINANCIAL POLICY**

Northwest Family Dental Care 27081 185<sup>TH</sup> Ave S.E. Covington, Washington 98042

In the interest of both good dentistry and good business, we believe it's best to establish a policy to avoid any misunderstandings later. As a result, we have developed this billing policy.

**1. Insurance claims-**

We will make every effort to verify eligibility and co-payment amounts prior to your visits. Please keep in mind that if you have recently undergone treatment at another office whose claims have not yet been processed by your insurance company, when we call to verify those benefits may not have been factored into your estimate and your ending balance may differ.

**2. You are responsible for paying your bill.**

Your insurance coverage is a contract between you and your insurance company. Our office is not involved in setting your coverage limits, exclusions to your contract, or waiting periods. This means it is primarily your responsibility to see that your insurance company covers your bill. It is also your responsibility to let us know if there is a change to your address or phone number.

**3. We ask that you pay your portion on the day the services are rendered.**

If you would like to put your balance on your credit or debit card, we accept: VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS. Further, we are pleased to offer a financing option which is administered through CARECREDIT. We also accept payments via cash or check.

**4. Cancellations-**

Your time is of great importance to us; therefore, appointments in our office are scheduled exclusively to accommodate each individual patient. This ensures a steady flow and enables us to stay on time. We sincerely ask that our patients respect this policy, as sudden cancellations are hard on our schedule. 48 Hours notice is respectfully required. 24 Hours notice is required to avoid a minimum of \$50.00 per hour charge.

By signing below, 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 dental insurance that I may have. I understand that all patient portions for service are due at the time of my appointment and that portions billed to my insurance are to be paid in full within 90 days from the date of service, regardless of whether or not my insurance has provided reimbursement. One percent per month interest (12% per year) will be charged on accounts delinquent 90 days from treatment date and any balance must be cleared upon receipt of my statement.

---

Signature of Patient or Responsible Party

Printed Patient Name

Date

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Northwest Family Dental Care 27081 185<sup>TH</sup> Ave S.E. Covington, Washington 98042

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed by **Northwest Family Dental Care**, of the Notice of Privacy Practices, that contain 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 **Northwest Family Dental Care** 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.

Here at **Northwest Family Dental Care** the doctors and staff take digital photographs of patients for identification purposes and documentation of procedures. Photos may also be used for teaching and representation to train other staff and patients. These photos are never sold to a third party and no personal details (i.e. name or address) are ever accessible to the public. If you do not fully understand any of the above, please ask.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

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

Relationship to Patient (if under 18): \_\_\_\_\_

Dependent family members also covered by this acknowledgement:

---

---

### 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 information to the persons indicated below:

(Check one)

- Any member of the immediate family
- Spouse/Partner only
- Other (please specify) \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES

Northwest Family Dental Care 27081 185<sup>TH</sup> Ave S.E. Covington, Washington 98042

This notice describes how medial information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.

Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.

Health Care Operations include the business aspects of running our practice.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use our confidential information to remind you of an appointment by sending reminder postcards, emails, text messages and/or leaving messages at home, work, and/or cell. Any other uses and disclosures will be made only with your written authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

The right to request restrictions on certain uses and disclosures of protected health information from us by alternative means or at alternative locations.

The right to request to received confidential communication of protected health information from us by alternative means or at alternative locations.

The right to access, inspect, and copy your protected health information.

The right to request an amendment of your protected health information.

The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

The right to obtain a paper copy of this notice from us upon request.

We require by law to maintain the privacy or your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of June, 2003 and we are required to abide to the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the term of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filling a complaint.

For more information about your Privacy Practices, please contact for more information about HIPPA or to file a complaint:

Julie Hawken- Privacy Officer  
Northwest Family Dental Care  
27081 185<sup>th</sup> Ave Se, Suite B-105  
Covington, WA 98042

The U.S. Department of Health and Human Services  
Office of Civil Rights  
200 Independence Ave SW  
Washington, D.C. 20201 877-696-6775