West Valley Dental

Welcome to our office. To assist us in serving you please complete the following form. The information provided on this form is important to your dental health. Information is completely confidential.

A. PERSONAL INFORMATION (If patient is a minor, form must be completed by parent)

Today's Date_____ *Is another family member a patient at this office? Y N*

Patient Name_____ Male_____Female_____

Home Address_____Birthdate_____

City / State_____Zip Code_____SSN_____

Home Phone_____Cell Phone_____Work Phone_____

E-Mail Address (to confirm appointments)_____

Employer_____Occupation_____

If patient is a minor: **Name of Parent**_____

Person financially responsible for account_____

EMERGENCY CONTACT: Name of person not living with you_____

Relationship_____**Phone**_____

B. DENTAL INSURANCE INFORMATION_____

Subscriber's Name_____**Primary Insurance Company**_____

Group/Policy #_____Birthdate_____SSN_____

Are you covered by a 2nd plan? Y N Insurance Co._____Group/Policy #_____

Subscriber's Name_____Birthdate_____ SSN_____

CONSENT: I authorize the staff of West Valley Dental to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by West Valley Dental to make a thorough diagnosis of the patient's dental needs. I also authorize West Valley Dental to perform any and all forms of treatment, medication, therapy, that may be indicated and further authorize and consent that West Valley Dental choose and employ such assistance as they deem fit. I also understand the use of anesthetic agents embodies a certain risk.

APPOINTMENTS: I understand **there will be a $75.00 charge per hour for patients who cancel or miss appointments without two-business days notice.**

INSURANCE: I hereby authorize payment of Group Insurance Benefits, otherwise payable to me, directly to West Valley Dental to be applied against my account. I also authorize West Valley Dental to provide any insurance company(s) information concerning health advice, treatment or pre-authorization for treatment, and supplies provided for the purpose of evaluating and administrating claims for benefits.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the above information is true and correct. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist or his staff of any changes at any subsequent appointment.

Print Name:_____

Signature:_____ **Date:**_____

Parent or Guardian:_____ **Date:**_____

West Valley Dental

Welcome to our office. To assist us in serving you please complete the following form. The information provided on this form is important to your dental health. Information is completely confidential.

DENTAL HEALTH HISTORY

	YES	NO
1. Do you want to learn to control dental disease and retain your teeth?	_____	_____
2. Would you like to change the color or appearance of your teeth?	_____	_____
3. Do your gums bleed when brushing?	_____	_____
4. Have you ever had an ongoing problem with bad breath?	_____	_____
5. Are your teeth sensitive?	_____	_____
6. Do you smoke or chew tobacco?	_____	_____
7. Do you drink alcohol? If so, how much?_____	_____	_____
8. Have you had any teeth removed? If so, when?_____	_____	_____
9. Do you gag easily?	_____	_____
10. Have you had a blow to the jaw? If so, when?_____	_____	_____
11. How often do you brush?_____		
12. How often do you floss?_____		

13. Have you ever had an adverse reaction to local anesthetic?_____

14. Have you had problems with previous dental treatment?_____

15. Why did you leave your last dentist?_____

MEDICAL HEALTH HISTORY

16. Are you currently taking any medications, drugs, pills, or alternative (herbal) medicines? **Y N** If yes, please list:

_____

17. Are you aware of being allergic to or have you ever reacted adversely to any of the following? **Y N**

a. Penicillin or other antibiotics
b. Aspirin, Acetaminophen or Ibuprofen
c. Codeine or other narcotics
d. Sulfa drugs
e. Latex or rubber dam
f. Reaction to costume jewelry or metals
g. Sedatives or sleeping pills
h. other (please specify)_____

18. Do you have, or have you had any of the following? (Please mark YES or NO for each)

Heart Problems		Allergy Problems	
Chest pain	Y N	Hayfever	Y N
Shortness of breath	Y N	Sinus problems	Y N
Blood pressure problems	Y N	Skin rashes	Y N
Heart murmur	Y N	Asthma	Y N
Heart valve problem	Y N		
Taking heart medication	Y N	Intestinal Problems	
Rheumatic fever	Y N	Ulcers	Y N
Pacemaker	Y N	Special diet	Y N
Artificial heart valve	Y N	Kidney or bladder problems	Y N
Blood Problems		**Bone or Joint Problems**	
Easy bruising	Y N	Arthritis	Y N
Frequent nosebleeds	Y N	Joint replacement	Y N
Abnormal bleeding	Y N		
Blood disease (anemia)	Y N	Diabetes	
Ever require a blood transfusion	Y N	Thirsty or mouth is dry	Y N

Fainting spells, seizures or epilepsy	Y N	Hepatitis, jaundice or liver trouble	Y N
Frequent or severe headaches	Y N	Herpes or other STD	Y N
Thyroid problems	Y N	HIV-positive / AIDS	Y N
Persistent cough or swollen glands	Y N	Glaucoma	Y N
Premedications required by physician	Y N	History of head injury	Y N
Tuberculosis or other respiratory disease	Y N	Epilepsy or other neurological disease	Y N
Cancer / tumor	Y N	History of alcohol or drug abuse	Y N

If you answered yes to any of the above, please provide a short description:

_____

Do you have any disease, condition or problem not listed above that you feel we should know about?_____

_____

Are you currently being treated by a physician? If so, for what? Please provide physician's name & phone number:

_____

19. During the past 12 months, have you taken any of the following?

Antibiotics or sulfa drugs	Y	N
Anticoagulants (e.g. Coumadin)	Y	N
High blood pressure medication	Y	N
Tranquilizers	Y	N
Insulin, Orinase, or similar drug	Y	N
Aspirin	Y	N
Digitalis or drugs for heart trouble	Y	N
Cortisone (steroids)	Y	N
Natural remedies	Y	N

Other_____

WOMEN: a. Are you taking oral contraceptives or other hormones? Y N

b. Are you pregnant?_____If yes, what month?_____

c. Name and phone number of OB/GYN:_____

If you are pregnant, then you must provide <u>prior to your first treatment appointment</u>, a note from your physician authorizing x-rays, medications and/or dental treatment. Please mention to our receptionist.

_____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I hereby certify that the above information is true and correct. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist or his staff of any changes at any subsequent appointment.

Print Name:_____

Signature:_____ Date:_____

Parent or guardian:_____ Date:_____

West Valley Dental
15668 West Valley Hwy • Tukwila, WA 98188 • (425) 430-9099

OUR CANCELLATION POLICY

In order to provide the best possible service to you we ask that you take a moment to read the following information regarding your appointments.

Your appointment time is especially reserved for you. If you must cancel an appointment please notify us as soon as you know you will not be able to keep your scheduled appointment.

Any change in your appointment greatly affects our patients and staff. When a patient does not show, or cancels or reschedules his or her appointment within less than 48-hours, it deprives others of timely care, and wastes dentist and staff time. More importantly, your dental treatment is delayed, which in many cases further complicates the condition and adds to your expense.

If you cannot keep your appointment, you are expected to contact our office during regular work hours with at least 2-business days notice.

Appointments cancelled without 2-business days notice and complete "no-show" appointments will be charged $50 per scheduled hour. Additionally, patients who repeatedly miss their appointments may be subject to dismissal from future care by this office.

Thank you, in advance, for your understanding and consideration.

I have read the Cancellation Policy and I understand and agree to abide by this Policy:

_____ _____

Signature of Patient or Responsible Party Date

_____

Print Name

West Valley Dental
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OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best and most appropriate dental care to suit your individual needs. To facilitate quality care, we believe it is important that you be kept well informed. Good communication is essential to a healthy provider-patient relationship.

The following financial policy will assist you in handling your account with us. Please read this form carefully and sign below. We are happy to answer any questions, please do not hesitate to ask.

INSURANCE:

Acceptance of Insurance: As dental care providers we must emphasize that our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract except where we are preferred provider. Your plan benefits depend solely on what your employer wishes to offer you and your fellow employees. The extent of coverage has nothing to do with the level of service provided by our office and the fee charged for these services. **While the filling of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered.**

For your convenience, we will call your insurance company to verify patient eligibility as well as obtain an estimate of insurance coverage. **However, insurance plans vary greatly in the types of coverage they offer and we expect you to become familiar with your policy's benefits and limitations.** Furthermore, as your insurance company will inform you when you call, "benefits quoted are not a guarantee of payment as they are subject to current plan provisions or eligibility." You will be held financially responsible for services, which are not covered by your insurance plan.

Based on information provided by your insurance company, we will provide an estimate that will show expected insurance payment and estimated patient payment for each procedure. However, the estimated insurance payment should be considered a guideline until the final insurance payment is received and posted to your account. Please note that our fees may not correspondence with those of your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates (UCR). If you have questions regarding UCR, please ask. **Our office CANNOT GUARENTEE the insurance payment as estimated.**

You will receive a statement each month to keep you informed of the status of your account. Your billing statement will reflect recent activity on your account including payments received and payment due from you or your insurance company. You are responsible for any payment not made by you insurance company within 60 days. We cannot accept responsibility of collecting an overdue insurance claim or for negotiating a disputed claim. However, we will make every effort to assist you with any questions or concerns you may have regarding your account.

FEES & PAYMENTS:

We share your concerns about the cost of dental care. Our fees have been thoughtfully worked out to reflect fair charges for our time, expertise, materials and the complexity of your treatment.

We are a fee-for-service practice. We expect payment in full at the time of service. We accept cash, checks and major credit cards.

Financing/Payment Plans: For the convenience of our patients, we offer payments through various outside financing companies. Information about those programs are available upon request. Please ask to speak with our Patient Care Coordinator.

FINANCIAL ARRANGEMENTS:

To minimize any fee-related misunderstandings, we make financial arrangement before starting treatment. The treatment fee is based on information gained from an examination of the patient and review of patient information. Should additional problems arise as treatment progresses, this estimated fee might be revised. The patient will be informed of any increased fees and/or additional recommended treatment. Any treatment cost not covered by insurance will be due at the time of treatment unless prior arrangements have been made.

Returned Checks: There will be a $25.00 handling charge for any returned checks.

Finance Charge: The total balance of account is subject to a 1.5% per month (18% APR) service charge after 60 days. If any installments are not paid when due, the whole, unpaid balance may, at our option, become immediately due.

I have read the Financial Policy and I understand and agree to this Financial Policy:

_____ **Date:**_____

Signature of Patient or Responsible Party

_____

Print Name

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires 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. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, 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 our health information.

Without specific written authorization, we are permitted to use and disclose your protected health information (PHI) for the purposes of providing your treatment, obtaining payment and conducting health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care within our office. In addition, we may share your health information with specialists, physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

- **Payment** means such activities as obtaining insurance reimbursement for services rendered, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information on an invoice used to collect payment for treatment you receive in our office, when billing your dental insurance for your dental services or determining the coverage allowed by your benefits plan.

- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for business planning and development that involves conducting cost-management and plan-related analysis related to managing and operating the entity, including formulary development and administration, necessary to facilitate needed care.

Unless you request otherwise, we may use or disclose your PHI to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care.

In addition, we may disclose your health information to insurance companies or government appointed agencies as part of their quality assurance and compliance care.

In addition, because we believe regular care is very important to your oral and general health, we may use your confidential information to remind you of scheduled appointments or that it is time for you to contact us and make an appointment by sending you reminder postcards, letters and/or leaving messages or voicemail at home and/or work. We may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

In addition, we may disclose your health information for public oversight activities, for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or report suspected abuse, neglect, or domestic violence.

Any other use and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your 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 used and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee will be assessed for duplication and assembly of your copy.
- The right to request an amendment to your protected health information. We may however, deny your request if the health information in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.
- The right to receive and accounting of disclosures of protected health information make for any reason other than for treatment, payment, or health care operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of 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 takes effect on April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We are required to abide by the terms of the 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 & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. To do so, please request a complaint form from our privacy director. We will not retaliate against you filing a complaint.

For more information about our Privacy Practices, please contact:
Privacy Officer
15668 West Valley Hwy
Tukwila, WA 98188
(425) 430-9099

For more information about HIPAA or to file a complaint:
US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
(877) 696-6775

West Valley Dental
15668 West Valley Hwy • Tukwila, WA • 98188
PHONE: (425) 430-9099

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 (HIPPA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up 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 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 above address 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. I also 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.

Patient Name:_____ Date:_____

Signature:_____ Date:_____

Relationship to Patient:_____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:_____ Ititials:_____ Reason:_____