WELCOME TO OUR OFFICE

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

OFFICE HOURS We are open Monday 8 a.m. to 5:00 p.m.; Tuesday 7:00 a.m. to 5:00 p.m.; Wednesday and Thursday 8:00 a.m. to 5:00 p.m.; Friday 7:00 a.m. to 3:00 p.m.

PARKING Parking is available in our building, with access at the bottom of Cherry Street on the North side. Street parking is also available on two hour parking meters on each street surrounding our location.

APPOINTMENTS We know there are times when you cannot keep your appointment. If this happens, we require 48 hours notice so we may utilize this time for another patient.

INSURANCE At your first appointment, please bring us your insurance information, forms, policy holder's card, and/or group number to expedite insurance processing. Helping you submit your insurance claims is a courtesy we offer all of our patients.

BROADWAY
E UNION ST
BOREN AVE
MADISON ST
Seattle University
Swedish Medical Cntr
E CHERRY ST *(James turns into Cherry)*
CHERRY ST
JAMES ST
I-5
12TH AVE
N
W
E
S
E YESLER WAY
S JACKSON ST

MADISON ST
CHERRY ST
JAMES ST
BROADWAY
Cherry street dead-ends, with parking under our building.

600 Broadway Suite 330 Seattle, WA 98122 P 206.325.0166 W dentalcareseattle.com

Employer/Occupation

Physician/Location

Are you allergic to:

☐ Penicillin? ☐ Codeine? ☐ Latex?

Other allergies?

Current medications?

(Women) Are you pregnant?

Do you have a history of any of the following? Please check:

- ☐ Artificial heart valve
- ☐ Heart surgery
- ☐ Heart disease
- ☐ Heart murmur
- ☐ Pacemaker
- ☐ Diabetes
- ☐ Radiation treatment
- ☐ HIV
- ☐ Prolonged bleeding
- ☐ Other?
- ☐ Cancer/Tumor
- ☐ Bis-phosphonates
- ☐ Artificial joint
- ☐ Diet drugs
- ☐ Anemia
- ☐ Hepatitis/liver disease
- ☐ Sinus trouble
- ☐ Surgery
- ☐ Sleep disorder
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Asthma
- ☐ High blood pressure
- ☐ Ulcers
- ☐ T.B. or lung disease
- ☐ Arthritis
- ☐ Tobacco use
- ☐ Thyroid disorder

Comments:

PATIENT REGISTRATION FORM

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DATE: ____ / ____ / ____ **PREFERRED NAME:** ____________________

NAME	SEX ☐M ☐F	☐CHILD ☐SINGLE ☐MARRIED ☐OTHER	BIRTH DATE
SPOUSE'S NAME/PARENT'S NAME (IF MINOR)	YOUR SOC. SEC. #		HOME PHONE
ADDRESS	CITY	ZIP	CELL PHONE
WHO REFERRED YOU?	EMPLOYER	OCCUPATION	WORK PHONE
YOUR EMAIL ADDRESS	EMERGENCY CONTACT (OTHER THAN SPOUSE)		EMERGENCY CONTACT'S PHONE

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE	GROUP #/EMPLOYER	NAME OF SUBSCRIBER (OTHER THAN SELF)	BIRTH DATE	INS. ID # OR SOC. SEC. #
SECONDARY DENTAL INSURANCE	GROUP #/EMPLOYER	NAME OF SUBSCRIBER (OTHER THAN SELF)	BIRTH DATE	INS. ID # OR SOC. SEC. #

MEDICAL INFORMATION & HISTORY

Are you allergic to Penicillin? .... Y N
Codeine? .... Y N
Other Medications? .... Y N
Latex? .... Y N
Are you taking any medication? .... Y N
Please list (on back): ____________
For what purpose? ____________
Are you subject to prolonged bleeding? Y N
Do you use tobacco products? .... Y N
Date of last physical exam: ____________
(Woman) Are you pregnant? .... Y N
How long? ____________
Are you taking oral contraceptives? ..... Y N
Name of Physician: ____________

DO YOU HAVE HISTORY OF THE FOLLOWING?
Bis-phosphonates .... Y N
Heart Disease/defect .... Y N
Artificial heart valve .... Y N

Heart murmur .... Y N
Heart surgery .... Y N
Pacemaker .... Y N
Artificial joints .... Y N
Diabetes .... Y N
Cancer/tumor .... Y N
High blood pressure .... Y N
Epilepsy .... Y N
Anemia .... Y N
Ulcers .... Y N
Tuberculosis or lung disease .... Y N
Asthma or hay fever .... Y N
Sinus trouble .... Y N
Hepatitis, Jaundice, or liver disease........ Y N
Arthritis .... Y N
Glaucoma .... Y N
Immune deficiency or HIV .... Y N
Radiation treatment .... Y N
Surgery .... Y N
Diet drugs .... Y N
Other? ____________

I am financially responsible for my own account. I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. If insurance coverage exists, I authorize payment to go directly to my dentist.

SIGNATURE ____________________ DATE ____________

FINANCIAL POLICY

For all treatment, we will be asking for payment of the portion of fees not covered by insurance at the time of your procedure.

METHODS OF PAYMENT Acceptable methods of payment are cash, check, Visa, Mastercard or debit cards. We offer a 5% discount if you pay in full by cash or check at the time of service. If you wish to pay in full at the time of service with a credit card, we will offer a 3% discount. Charges not paid at the time of service are due within 30 days.

INSURANCE As a courtesy, we will bill your insurance company for you if provided with all the proper billing information. All accounts are due within 60 days, regardless of insurance involvement. A 1.5% monthly finance charge will be assessed on all accounts past 60 days. You will receive a monthly statement regarding your account activity.

ESTIMATES We can provide a treatment plan with an estimate of total fees after the initial visit. This treatment plan will also include, in writing, a breakdown of our fees, the estimated insurance coverage, and your portion that will be due at each visit. We would like to emphasize that these are "estimates". Should additional unforeseen problems or complications arise as treatment progresses, you will be kept informed.

We reserve the right to charge your account $50 for any appointment that is cancelled or changed with less than 48 hours notice.

Please feel free to ask any questions you may have regarding these policies. We are most willing to help you in any way we can.

PATIENT SIGNATURE ____________________ DATE __________

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

PROTECTING YOUR PERSONAL HEALTH INFORMATION We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone—even family members—without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTH INFORMATION We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTH INFORMATION As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes.

We may use and/or disclose your health information to communicate reminders about your appointments including voicemail, answering machines, and postcards.

PATIENT RIGHTS You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge you for copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient in our practice. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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 Dental Care Seattle. 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 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.

Dental Care Seattle 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

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) ________