MARTIN J. MATOVICH, DMD

GENERAL & BIOESTHETIC DENTISTRY

PATIENT INFORMATION

NAME

LAST FIRST M.I.

ADDRESS

CITY STATE ZIP

HOME PHONE CELL PHONE

DATE OF BIRTH AGE SEX ☐ M ☐ F

SOCIAL SECURITY # - - EMAIL

HOW DID YOU HEAR ABOUT OUR OFFICE?

RESPONSIBLE PARTY (If same as above please skip)

NAME

LAST FIRST M.I.

ADDRESS

CITY STATE ZIP

HOME PHONE CELL PHONE

DATE OF BIRTH AGE SEX ☐ M ☐ F

SOCIAL SECURITY # - - EMAIL

RELATIONSHIP TO PATIENT

☐ SPOUSE ☐ CHILD ☐ OTHER

DENTAL INSURANCE

PRIMARY INSURANCE COMPANY

NAME OF INSURED

RELATIONSHIP TO PATIENT

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

GROUP NO. ID NO.

EMPLOYER

DATE OF BIRTH INSURED'S SOC. SEC. # - -

SECONDARY INSURANCE COMPANY

NAME OF INSURED

RELATIONSHIP TO PATIENT

☐ SELF ☐ SPOUSE ☐ CHILD ☐ OTHER

GROUP NO. ID NO.

EMPLOYER

DATE OF BIRTH INSURED'S SOC. SEC. # - -

PERSON TO CONTACT FOR EMERGENCY

NAME

LAST FIRST M.I.

PHONE

PHYSICIAN PHONE

PLEASE TURN OVER AND SIGN →

300 SE 120TH AVENUE, SUITE 400, VANCOUVER, WA 98683 | PHONE (360) 256-3570 | FAX (360) 896-0267 | DRMATOVICH.COM

MARTIN J. MATOVICH, DMD
GENERAL & BIOESTHETIC DENTISTRY

CONSENT FOR TREATMENT

I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

I agree to the use of anesthetic sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

I give consent to the doctor's or designated staff's use and disclosure of any oral, written or electronic health records that are individually identifiable as mine for the purpose of carrying out my treatment, payment and health care operations. I understand that only the minimum amount of information necessary to provide quality care will be used or disclosed and not a notice fully outlining the protection of my personal health information is available.

I hereby agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 - ½% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____

Date / /

Parent/Responsible Party's Signature _____

Relationship to Patient _____

Employee Witness _____

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DENTAL HISTORY

What is the reason for your visit today?

☐ CHECK-UP ☐ CLEANING ☐ TOOTHACHE ☐ OTHER

What was done at your last dental visit?

DATE OF LAST DENTAL VISIT

DATE OF LAST DENTAL CLEANING

DATE OF LAST FULL MOUTH X-RAYS (FMX)

PREVIOUS DENTIST'S NAME

TELEPHONE

ADDRESS

STATE ZIP

Do you have any dental problems currently?
If yes, please describe:

Do you feel nervous about having dental treatment?
If yes, please describe:

Is there anything else about having dental treatment that you would like us to know?
If yes, please describe:

Would you like to receive text message or e-mail reminders for appointments?

TEXT: **YES** ☐ **NO** ☐ E-MAIL: **YES** ☐ **NO** ☐

PLEASE COMPLETE OTHER SIDE →

Please check boxes below.
"Y" for YES and "N" for NO.

ARE ANY OF YOUR TEETH SENSITIVE TO:

- **Y** ☐ **N** ☐ Hot or cold?
- **Y** ☐ **N** ☐ Sweets?
- **Y** ☐ **N** ☐ Biting or chewing?
- **Y** ☐ **N** ☐ Have you noticed any mouth odors or bad tastes?
- **Y** ☐ **N** ☐ Do you frequently get cold sores, blisters, or any other oral lesions?
- **Y** ☐ **N** ☐ Do your gums bleed or hurt?
- **Y** ☐ **N** ☐ Have you noticed any loose teeth or change in your bite?
- **Y** ☐ **N** ☐ Does food tend to become caught between your teeth? If yes where?

HAVE YOU EXPERIENCED:

- **Y** ☐ **N** ☐ Clenching or grinding of your teeth?
- **Y** ☐ **N** ☐ Biting your lips or cheeks regularly?
- **Y** ☐ **N** ☐ Mouth breathing while awake or asleep?
- **Y** ☐ **N** ☐ Tired jaws, especially in the morning?
- **Y** ☐ **N** ☐ Snoring or having any other sleeping disorders?
- **Y** ☐ **N** ☐ Wearing a c-pap or sleep apnea appliance?
- **Y** ☐ **N** ☐ Smoke/chew tobacco or other tobacco products?
- **Y** ☐ **N** ☐ Clicking or popping of the jaw?
- **Y** ☐ **N** ☐ Pain? (TMJ, ear, side of face)
- **Y** ☐ **N** ☐ Difficulty in opening or closing mouth?
- **Y** ☐ **N** ☐ Difficulty in chewing on either side of mouth?
- **Y** ☐ **N** ☐ Headaches, neck-aches, shoulder aches?
- **Y** ☐ **N** ☐ Sore muscles? (neck, shoulders)

HAVE YOU EVER HAD:

- **Y** ☐ **N** ☐ Orthodontic treatment? (braces)
- **Y** ☐ **N** ☐ Oral surgery?
- **Y** ☐ **N** ☐ Periodontal treatment or deep cleanings?
- **Y** ☐ **N** ☐ A bite plate or night guard?
- **Y** ☐ **N** ☐ A serious injury to the mouth or head?

MEDICAL HISTORY

1.) Are you in a physician's care at this time?	☐ YES ☐ NO	PHYSICIAN'S NAME	PHONE
2.) Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva, or other bisphosphonates?	☐ YES ☐ NO	*If yes, please list name & dosage:*	
3.) Are you aware of having an **allergic** (or adverse) reaction to any substance or medication?	☐ YES ☐ NO	*If yes, please specify:*	
4.) Do you have or have had any disease, condition, or problem not listed?	☐ YES ☐ NO	*If yes, please specify:*	
5.) Have you ever been told to take a pre-medication prior to dental treatment?	☐ YES ☐ NO	*If yes, please list name & dosage:*	
6.) Are you taking any medications, drugs, pills, or herbal remedies at this time, including regular dosages of aspirin?	☐ YES ☐ NO	*If yes, please list name & dosage:*	
7.) Have you been hospitalized within the last six months with heart attacks, stroke, or joint replacements?	☐ YES ☐ NO		

PLEASE INDICATE IF YOU HAVE, OR HAVE HAD ANY OF THE FOLLOWING

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS/HIV+	☐	☐	DIET (SPECIAL/RESTRICTED)	☐	☐	MITRAL VALVE PROLAPSE
☐	☐	ANEMIA	☐	☐	DRUG ADDICTION	☐	☐	NERVOUS/ANXIOUS
☐	☐	ARTHRITIS RHEUMATISM	☐	☐	EMPHYSEMA	☐	☐	NEUROLOGICAL DISORDERS
☐	☐	ARTIFICIAL JOINTS	☐	☐	EPILEPSY OR SEIZURES	☐	☐	PSYCHIATRIC CARE
☐	☐	ASTHMA	☐	☐	EPINEPHRINE SENSITIVITY	☐	☐	PACEMAKER
☐	☐	ARTIFICIAL HEART VALVE	☐	☐	FAINTING OR DIZZY SPELLS	☐	☐	RHEUMATIC FEVER
☐	☐	BLOOD TRANSFUSION	☐	☐	GLAUCOMA	☐	☐	SICKLE CELL DISEASE
☐	☐	BRUISE EASILY	☐	☐	HAY FEVER/ALLERGY/HIVES	☐	☐	SINUS TROUBLE
☐	☐	CANCER	☐	☐	HEART ATTACK	☐	☐	SLEEP APNEA
☐	☐	CHEMO/RADIATION	☐	☐	HEART MURMUR	☐	☐	STROKE
☐	☐	CHEST PAIN	☐	☐	HEMOPHILIA	☐	☐	SWOLLEN ANKLES
☐	☐	CHRONIC COUGH	☐	☐	HEPATITIS A B C (CIRCLE)	☐	☐	THYROID PROBLEMS
☐	☐	COLD SORES/FEVER BLISTERS	☐	☐	HIGH BLOOD PRESSURE	☐	☐	TMD OR TMJ
☐	☐	CONGENITAL HEART DISEASE	☐	☐	KIDNEY TROUBLE	☐	☐	TOBACCO USE
☐	☐	CORTISONE MEDICINE	☐	☐	LATEX SENSITIVITY	☐	☐	TUBERCULOSIS
☐	☐	COSMETIC SURGERY	☐	☐	LIVER DISEASE/JAUNDICE	☐	☐	TUMORS
☐	☐	DIABETES	☐	☐	LOW BLOOD PRESSURE	☐	☐	VENEREAL DISEASE

Patient's Name _____ **Date** _____ /_____ /_____

MARTIN J. MATOVICH, DMD
GENERAL & BIOESTHETIC DENTISTRY

OFFICE AND FINANCIAL POLICIES

Our office strives to provide the best dental care in a safe and sterile environment for all of our patients. To ensure we are able to provide the best dental care to our patients we do collect any patient portions due at the time of each appointment. We will make every effort to provide you with a financial estimate once the dentist provides a treatment plan of your needs. Our office will offer to contact your insurance as a courtesy. Any insurance estimate is not a guarantee of payment. If you do need to make payments on your dental treatment we offer *Care Credit*. *Care Credit* offers 6 months deferred no interest or 24 months, 36 months or 48 months with interest. We accept: cash, check, Visa, MasterCard, Discover, and American Express.

The patient is responsible for all dental services provided in our office regardless of any dental insurance. If you do have dental insurance we will send your claim to your insurance company. If your dental insurance company does not pay in a timely manner you are responsible for all dental services that are not covered.

Collection Agency
If there is a balance on the account over 90 days our office charges an interest rate of 18% and accounts will be sent to a collection agency. You are responsible for all interest, collection, and attorney fees.

Appointment Cancellations *(missed or short notice)*
The first time an appointment is missed or short notice canceled, it will be noted in your chart and we will remind you about our policy. The second time our office charges a no show/short-notice cancellation fee of a minimum $25.00 for hygiene appointments and a higher fee for appointments with the dentist. Continued cancellations or missed appointments may result in being released from care. As a courtesy to other patients, if you are late to your appointment, you may be asked to reschedule.

Dependent Children
For children, our office collects from the parent who brings the patient in for the appointment. You are responsible for your children's actions at all times. Our office staff will assist you with your well-behaved children if needed. If the case arises where the parent is unable to come in to the appointment with their child, the financial transaction needs to be handled ahead of time. Our office does not get involved with issues regarding separated parents and finances.

If the child is 18 or older, they are legally responsible for all financial obligations. If the parents agree to be financially responsible, both parties are liable for any charges on the account.

I hereby agree to the office and financial policies for Dr. Martin Matovich and Associates by signing below.

Patient Name _____ **Date** / /

Patient/Parent/Guardian Signature _____ **Date** / /

Employee Witness _____ **Date** / /

MARTIN J. MATOVICH, DMD
GENERAL & BIOESTHETIC DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT

I, _____ have read and/or received a copy of this office's **Notice of Privacy Practices**.

Patient Signature _____ **Date** / /

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our **Notice of Privacy Practices**, but acknowledgement could not be obtained because: (PLEASE CHECK BELOW)

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify below)

_____

_____

_____

_____

Employee Witness _____ **Date** / /

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MARTIN J. MATOVICH , DMD

GENERAL & BIOESTHETIC DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY – THE PRIVACY OF YOUR HEALTH IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect January 1, 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 reserve the right to make changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice upon available request.

You may request a copy of our notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conduction training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

USES AND DISCLOSURES OF HEALTH INFORMATION CONTINUED

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody or protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may or disclose your health information to provide you with appointment reminders (such as a voicemail, postcard, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by contacting the Privacy Officer listed at the end of this Notice. You may also request access by sending a letter to the address at the end of this Notice. We will charge a reasonable fee, established by the State of Washington, for expenses such as copier and staff time. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact the Privacy Officer listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement.

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make this request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

PRIVACY OFFICER: LISA BROWN
300 SE 120TH AVE , SUITE 400, VANCOUVER, WA 98683
PHONE (360) 256-3570 | FAX (360) 896-0267