Mark J. Andrews, DDS
7311 NE 141st Street, Suite 1
Kirkland, Washington 98034
425-821-8100

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 Mark J. Andrews, DDS. 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 office 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.

Mark J. Andrews, DDS 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 THIS LINE

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):

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 principal 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 Healthcare 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 (PHI)

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 without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

Your Rights as our Patient

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 for your 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.

Please ask if you have any questions about your privacy rights or the protection of your health information.

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MARK J. ANDREWS, D.D.S.

PATIENT REGISTRATION

All information is CONFIDENTIAL

Email Address _____

Home Phone _____

Patient _____ Birthdate _____ Work Phone _____
LAST NAME FIRST NAME INITIAL

Address _____ Age _____ Mobile Phone _____

_____ Social Security No. _____
CITY STATE ZIP CODE

Spouse's Name or Parent if a minor _____

Person Responsible for Account _____

Whom may we thank for this referral? _____

DENTAL INSURANCE:

Insurance Co. _____

Address _____

Subscribers Name _____

Group No. _____ SSN _____

Subscribers Address _____

Subscribers Date of Birth _____

Employer _____

City _____ State _____ Zip _____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

Is patient covered by additional insurance? ☐ No ☐ Yes

Insurance Co. _____

Address _____

Subscribers Name _____

Group No. _____ SSN _____

Subscribers Address _____

Subscribers Date of Birth _____

Employer _____

City _____ State _____ Zip _____

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child

MEDICAL HISTORY

In case of emergency, notify _____
NAME PHONE RELATIONSHIP

Name, Address & Phone# of Physician _____

Do you have or have you had any of the following: *[Check the appropriate box(es)]*

- ☐ Allergies to Anesthetics
- ☐ Allergies to Medication
- ☐ Allergies to _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
  Type _____
- ☐ Diabetes
- ☐ Dry Mouth
- ☐ Epilepsy
- ☐ Excessive Bleeding/Bruising
- ☐ Fibromyalgia
- ☐ Heart Murmur
- ☐ Heart Trouble
- ☐ Heart Valve Replacement
- ☐ Hepatitis
- ☐ High/low Blood Pressure
- ☐ HIV Positive
- ☐ Joint(s) Replacement
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Mitral Valve Prolapse
- ☐ M.S.
- ☐ Osteoporosis
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stroke(s)
- ☐ Sjögren's
- ☐ Surgery
- ☐ Thyroid Problem
- ☐ Tuberculosis

Please list all medication you are taking _____

_____

Are you pregnant? ☐ Yes ☐ No

Are the any other medical conditions that may possibly affect your dental treatment? ☐ Yes ☐ No

If yes please describe _____

DENTAL HISTORY

Do you have or have you had any of the following: *[Check the appropriate box(es)]*

- ☐ Bleeding Gums
- ☐ Periodontal Treatment
- ☐ Clenching or Grinding
- ☐ Difficulty Chewing
- ☐ Frequent Blisters on Lips or Mouth
- ☐ Swelling or Lumps in Mouth

Date of last dental examination _____

Are you experiencing any dental discomfort at this time? ☐ Yes ☐ No If yes, please describe _____

Are you satisfied with the appearance of your teeth? ☐ Yes ☐ No

Are you fearful of dental treatment? ☐ Yes ☐ No

I understand that the total payment of the fee for dental services is my responsibility and not that of the insurance company. I agree to pay for all services rendered.

Signature _____ Date _____