



Maple Valley FAMILY DENTAL CARE

Patient Information

Patient Name _____

Mailing Address _____ City _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Birth Date: ___/___/___ Age: _____ Sex: Male Female

Social Security: _____ Drivers License: _____

Emergency Contact: _____ Phone Number: _____

How did you hear about our office: _____

Would you like to receive email correspondences from our office? Yes No

Would you like to receive text messaged from our office? Yes No

Responsible Party (if different from patient)

Name _____

Mailing Address _____ City _____ State _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Social Security: _____ Birth Date: ___ / ___ / ___

Drivers License: _____ Relationship to Patient _____

Insurance Information

PRIMARY INSURANCE: _____ SECONDARY INSURANCE: _____

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: _____

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Are you under a physician's care now?
Have you ever been hospitalized or had a major operation?
Have you ever had a serious head or neck injury?
Are you taking any medications, pills, or drugs?
Do you take, or have you taken, Phen-Fen or Redux?
Are you on a special diet?
Do you use tobacco?
Do you use controlled substances?

Women: Are you Pregnant/Trying to get pregnant? Taking oral contraceptives? Nursing?

Are you allergic to any of the following? Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics Other

- Do you have, or have you had, any of the following? AIDS/HIV Positive, Alzheimer's Disease, Anaphylaxis, Anemia, Angina, Arthritis/Gout, Artificial Heart Valve, Artificial Joint, Asthma, Blood Disease, Blood Transfusion, Breathing Problem, Bruise Easily, Cancer, Chemotherapy, Chest Pains, Cold Sores/Fever Blisters, Congenital Heart Disorder, Convulsions, Cortisone Medicine, Diabetes, Drug Addiction, Easily Winded, Emphysema, Epilepsy or Seizures, Excessive Bleeding, Excessive Thirst, Fainting Spells/Dizziness, Frequent Cough, Frequent Diarrhea, Frequent Headaches, Genital Herpes, Glaucoma, Hay Fever, Heart Attack/Failure, Heart Murmur, Heart Pace Maker, Heart Trouble/Disease, Hemophilia, Hepatitis A, Hepatitis B or C, Herpes, High Blood Pressure, Hives or Rash, Hypoglycemia, Irregular Heartbeat, Kidney Problems, Leukemia, Liver Disease, Low Blood Pressure, Lung Disease, Mitral Valve Prolapse, Pain in Jaw Joints, Parathyroid Disease, Psychiatric Care, Radiation Treatments, Recent Weight Loss, Renal Dialysis, Rheumatic Fever, Rheumatism, Scarlet Fever, Shingles, Sickle Cell Disease, Sinus Trouble, Spina Bifida, Stomach/Intestinal Disease, Stroke, Swelling of Limbs, Thyroid Disease, Tonsillitis, Tuberculosis, Tumors or Growths, Ulcers, Venereal Disease, Yellow Jaundice

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

Maple Valley Family Dental Care Financial Policy

27016 Maple Valley-Black Diamond Road SE

Maple Valley, WA 98038

(425) 413 8525

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 been processed by your insurance company when we call, 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 company. Our office is not involved in setting your coverage limits, exclusions to your contract, or waiting periods. This means it's primarily your responsibility to see that your insurance company covers your bill.

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

If you would like to put your balance on your credit or debit card, we accept the following: **VISA, MasterCard, Discover & American Express.**

We are pleased to offer a financing option which is administered through:

CARECREDIT

For our uninsured and senior patients (age 62+) we are happy to offer a 5% discount at the time of your visit. Services must be paid in full with either cash or check to honor discount.

4. **To accommodate our patient's time and busy schedule, we schedule exclusive appointments for each patient and always strive to stay on time. We sincerely ask that our patients respect this policy, as sudden cancellations are hard on our schedule.**

48 Hours Notice respectfully required

24 Hours Notice required to avoid a \$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 services are due at appointment time 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 (1%) per month interest, (12%) per year will be charged on accounts 90 days from the treatment date and any balance must be cleared upon receipt of my statement.

Signature (responsible party)

Print Name

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Maple Valley Family Dental Care, 27016 Maple Valley-Black Diamond Rd SE, Maple Valley WA, 98038

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and 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 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 address above 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 and I 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: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgment:

Additional Disclosure Authority:

Any member of my immediate family _____ Yes No

Spouse only _____ Yes No

Other-specify _____ Yes No

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency situation
- Other

NOTICE OF PRIVACY PRACTICES

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 (HIPAA) 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 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. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

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 your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Any other uses and disclosures 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 uses 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 at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to 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 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 is effective as of _____, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms 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 & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

For more information about HIPAA or to file a complaint:

Privacy Officer

Office Name **Maple Valley Family Dental Care**
Address **27016 Maple Valley Black Diamond Rd SE**

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201