

PATIENT REGISTRATION

ID: _____ Chart ID: _____

First Name: _____ Last Name: _____ Middle Initial: _____

Patient Is: Policy Holder Preferred Name: _____

Responsible Party

Responsible Party (if someone other than the patient)

First Name: _____ Last Name: _____ Middle Initial: _____

Address: _____ Address 2: _____

City, State, Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Birth Date: _____ Soc Sec: _____ Drivers Lic: _____

Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Patient Information

Address: _____ Address 2: _____

City: _____ State / Zip: _____ Pager: _____

Home Phone: _____ Work Phone: _____ Ext: _____ Cellular: _____

Sex: Male Female Marital Status: Married Single Divorced Separated Widowed

Birth Date: _____ Age: _____ Soc. Sec: _____ Drivers Lic: _____

E-mail: _____ I would like to receive correspondences via e-mail.

Section 2

Employment Status: Full Time Part Time Retired

Student Status: Full Time Part Time

Medicaid ID: _____ Pref. Dentist: _____

Employer ID: _____ Pref. Pharmacy: _____

Carrier ID: _____ Pref. Hyg.: _____

Section 3

Employer/Occupation?: _____

Lives With?: _____

Primary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

Secondary Insurance Information

Name of Insured: _____ Relationship to Insured: Self Spouse Child Other

Insured Soc. Sec: _____ Insured Birth Date: _____

Employer: _____ Ins. Company: _____

Address: _____ Address: _____

Address 2: _____ Address 2: _____

City, State, Zip: _____ City, State, Zip: _____

Rem. Benefits: _____ .00 Rem. Deduct: _____ .00

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? Yes No If yes, please explain: _____

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Do you take, or have you taken, Phen-Fen or Redux? Yes No _____

Are you on a special diet? Yes No _____

Do you use tobacco? Yes No _____

Do you use controlled substances? Yes No _____

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

Are you allergic to any of the following?
 Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics
 Other If yes, please explain: _____

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

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

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 of 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.

That means it's primarily your responsibility to see that your insurance company covers your bill.

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

If you would like to put your balance on your credit or debit card, we accept:

VISA MasterCard Discover American Express

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

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 a check.

4. To accommodate our patient's time and busy schedules, 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 treatment date and any balance must be cleared upon receipt of my statement.

Signature (responsible party)

Print Name

Date

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 **April 14, 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:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

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