

## Patient Information

**Patient's Name:** \_\_\_\_\_ Birthdate: \_\_\_\_\_  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_

**If patient is a minor, parent or guardian's name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street \_\_\_\_\_ Apartment # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ How long at this address? \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_ (Cellular): \_\_\_\_\_

Email address: \_\_\_\_\_ May we send email appointment reminders? \_\_\_\_\_

Social Security Number \_\_\_\_\_ Driver's License Number \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street \_\_\_\_\_ Phone # \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_ How long at this employer? \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**Address:** \_\_\_\_\_  
Street \_\_\_\_\_ Phone # \_\_\_\_\_  
\_\_\_\_\_ How long at this employer? \_\_\_\_\_

Insurance Company Name and Address \_\_\_\_\_

Subscriber Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Group Number \_\_\_\_\_

Do you have additional dental insurance? \_\_\_\_\_ Subscriber Name \_\_\_\_\_

Subscriber Social Security Number \_\_\_\_\_ Birthdate \_\_\_\_\_ Group Number \_\_\_\_\_

Secondary Insurance Company Name and Address \_\_\_\_\_

Please let us know how you heard about our office: \_\_\_\_\_

Nearest relative not residing with you \_\_\_\_\_ Relationship \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

Emergency contact: (someone other than responsible party) \_\_\_\_\_

Address: \_\_\_\_\_ Phone \_\_\_\_\_

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

## Health Information

**Have you ever had any of the following? Please circle only those that apply:**

Allergies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Head Injuries  
 Heart Disease  
 Chest Pain  
 Irregular Heartbeat  
 Mitral Valve Prolapse  
 Pacemaker  
 Heart Surgery  
 Hepatitis  
 High Blood Pressure  
 Kidney Disease  
 Liver Disease  
 Lumps/Swelling  
 Osteoporosis  
 Psychiatric Care  
 Respiratory Problems  
 Rheumatic Fever  
 Shortness of Breath  
 Sinus Problems  
 Stomach Problems

Stroke  
 Tuberculosis

Are you Pregnant?  
 Due date:  
 OTHER:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Arthritis  
 Asthma  
 Back/Neck Pain  
 Cancer  
 Diabetes  
 Dizziness  
 Emphysema  
 Epilepsy  
 Excessive Bleeding  
 Fainting  
 Fibromyalgia  
 Glaucoma  
 Hay Fever

- Have you ever had any dental complications?  Yes  No

If yes, please explain: \_\_\_\_\_

- Have you ever been told you need to take an antibiotic or pre-med prior to your dental appointment?  Yes  No

If yes, please explain: \_\_\_\_\_

- Have you ever had any reaction to latex?  Yes  No

If yes, please explain: \_\_\_\_\_

- Have you been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

- Has there been any change in your general health within the last year?  Yes  No

If yes, please explain: \_\_\_\_\_

- Are you now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

- Are you currently taking any medications including from the store (i.e. aspirin)?  Yes  No

If yes, please list: \_\_\_\_\_

- Are you currently taking any herbs or supplements?  Yes  No

If yes, please list: \_\_\_\_\_

- Have you been treated for alcohol or drug addiction?  Yes  No

- Do you have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

## Dental Information- Child

Does your child have a Nickname we should use? \_\_\_\_\_

Many different things affect a child's dental health. The three most important to developing teeth are home dental care (brushing, flossing and the use of fluorides), any habits relating to the mouth or teeth, and your child's diet. To help us better evaluate your child's dental health, please answer the following questions:

### HABITS

Did your child have a habit of sucking his/her thumb or finger?	YES	NO
Does your child chew ice?	YES	NO
Does your child grind his/her teeth?	YES	NO
Does your child have any other mouth habits? _____		

### HOME DENTAL CARE

When was your child's last dental appointment? \_\_\_\_\_  
Any significant dental history we should be aware of? \_\_\_\_\_

Does your child brush his/her own teeth? After every meal? ____ Every Morning? ____ Every Night? ____	YES	NO
Do you help brush your child's teeth?	YES	NO
How much toothpaste does your child use? _____		
Does he/she swallow it?	YES	NO
Does he/she use dental floss?	YES	NO
Does/did your child take fluoride drops or tablets?	YES	NO
Anything else you would like to add about the care of your child's teeth at home? _____ _____		

### DIET

Was your child put to bed with a bottle?	YES	NO
Does your child chew gum with sugar in it?	YES	NO
Is your child a "snacker"?	YES	NO
Would you like to make any comments about your child's diet? _____ _____		

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_

Date: \_\_\_\_\_

**All Smiles Dentistry**  
**9623 32nd Street SE, Suite B/05/106**  
**Everett, Washington 98205**  
**425-335-1111**

**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 All Smiles Dentistry. 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.

All Smiles Dentistry 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	<input type="checkbox"/>	YES	<input type="checkbox"/>
SPOUSE ONLY	<input type="checkbox"/>	YES	<input type="checkbox"/>
OTHER (PLEASE SPECIFY):	<input type="checkbox"/>	YES	<input type="checkbox"/>
		NO	<input type="checkbox"/>

\_\_\_\_\_  
**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?	<input type="checkbox"/>	YES	<input type="checkbox"/>
		NO	<input type="checkbox"/>
DATE PROVIDED:			
REASON FOR DENIAL:	<input type="checkbox"/>	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.	
	<input type="checkbox"/>	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.	
	<input type="checkbox"/>	UNABLE TO SIGN.	
	<input type="checkbox"/>	REASON NOT GIVEN.	
	<input type="checkbox"/>	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 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 to provide information to law enforcement as 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/ email messages, 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 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 let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

**All Smiles Dentistry**



## FINANCIAL & APPOINTMENT POLICY

We are committed to providing you with the best possible care and to a trusting partnership with you in your dental care. Your clear understanding of our Financial and Appointment Policy is important to our professional relationship. Please ask if you have any question about our fees, Financial and Appointment Policy, or your responsibility at any time.

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### **Your Payment is due at the time of treatment**

Payment for treatment is due at the time services are rendered. Prepayment for all laboratory fabricated dental treatment is required (crowns, onlays, bridges, dentures, etc.). We accept most major credit cards, personal check, money orders or cash. If you prefer a deferred payment option we offer Care Credit and Dental Fee Plan, simply ask for a short application and/or apply online.

### **Dental Benefits (Insurance) – We go the extra mile**

If you have dental benefits, we will make a good faith estimate of your benefits and defer billing you for that amount for up to 60 days. As a courtesy to you, we will file the appropriate claim forms with your dental benefit company. We will also track your dental claims, follow-up with your benefit provider when claims are not processed in a timely manner and attempt to expedite payment. We are also happy to provide your benefit carrier with x-rays or other information they may require in accordance with the Health Insurance Portability & Accountability Act (HIPAA).

If your dental benefit carrier denies coverage, or if we otherwise do not receive payment within 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your benefits carrier and/or your employer and your benefits provider. We will make every attempt to assist you in obtaining any benefits due you by your dental benefit provider.

**For all Patients:** Please help us to serve you, and our other patients, by keeping your scheduled appointments. We do require at least 48 HOURS NOTICE for any scheduling changes to avoid an appointment charge. To help compensate the cost of lost appointments, there will be a broken appointment charge of \$50.00 per each half hour of scheduled time.

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I understand that any delinquent balances are subject to a Finance Charge of 1% every month until balance is paid in full. Regardless of dental benefit coverage, I am responsible for the entire fee for any treatment rendered and any related expenses. I understand that I am responsible to pay reasonable attorney's fees and collection expenses incurred and expended in the event should my account be referred to an attorney or agency for collection.

**Assignment and release:** I authorize payment to be made directly to the dentist by my dental benefit company. I accept financial responsibility for all services whether covered or not by my dental benefit provider and I authorize release of any dental or medical care information requested by my benefit carrier.

Thank you for understanding our Financial & Appointment Policy. Please let us know if you have any questions.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature if different than Patient

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