Confidential Patient Information

Date: _____

PERSONAL INFORMATION

Name: _____

SS# (required for most insurance billing - ask us if this applies to your policy):_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home) _____ (Cell) _____

(Work)_____ (E-mail) _____

Preferred Contact Method (check preferred option for appointment reminders):

Text_____ Cell Phone_____ Home Phone_____ Email_____ Regular Mail_____

Birth date: _____ Sex: _____ Marital Status: _____

Occupation**:** _____ Spouse Name: _____

Referred by: _____OR

Circle one: TV Ad Radio Ad Print Ad Cinema Ad Social Media Other_____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ Relationship: _____ SS#:_____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (Home/Cell) _____/_____ Email_____

DENTAL INSURANCE INFORMATION

Primary Insurance Co/ POLICY #:_____

Insurance Co. Address: _____

Employee: _____ Birth Date: _____ Relationship: _____

SS#/ID#:_____**Employer**: _____

Secondary Insurance Co/ POLICY #:_____

Insurance Co. Address: _____

Employee: _____ Birth Date: _____ Relationship: _____

SS#/ID#:_____**Employer**: _____

I understand that payment for services is my obligation regardless of insurance or any other third party involvement.

SIGNATURE: _____ DATE:_____

Medical History

PATIENT NAME: _____ **Birth Date:** _____

Dental personnel primarily treat the area in and around your mouth. Since that part is attached to the rest of your body, certain health problems or medications that you may be taking could have an important role in the dentistry you will receive. Not informing us of a medical condition you have could directly be responsible for treatment complications and be dangerous to your health. You are responsible for informing us if your health condition or medications change. Thank you in advance for answering these questions:

Are you under a physician's care now? O No O Yes, explain_____

Have you ever been hospitalized or had a major operation? O No O Yes, explain_____

Have you ever had a serious head or neck injury? O No O Yes, explain_____

Are you taking any medications, pills or drugs O No O Yes, please explain and/or list below

_____ _____
_____ _____
_____ _____
_____ _____

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

Have you ever taken Fosamax, Boniva, Actonel or any other medications known as bisphosphonates? O No O Yes

Are you on a special diet? O No O Yes

Do you use tobacco? O No O Yes

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

Are you Allergic to any of the following:

O Aspirin	**O Penicillin**	**O Codeine**	**O Acrylic**
O Metal	**O Latex**	**O Sulfa Drugs**	**O Local Anesthetic**

Other, explain_____

Do you use controlled substances? O No O Yes, explain_____

Do you have, or have you had, any of the following?

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

Have you ever had any serious illness not listed? O No O Yes, 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 health. It is my responsibility to inform this dental office of any changes or medical status.

Signature of PATIENT, PARENT or GUARDIAN_____DATE_____

MISSED APPOINTMENT POLICY

Your scheduled appointment time is reserved just for you. We try not to overbook appointment times in order to provide excellent dental care and ensure we have sufficient time to adequately treat our patients.

We will make every effort to accommodate your scheduling needs. In return, we ask that you help us by keeping your scheduled appointments, arriving on time and notifying us a minimum of 24 hours in advance if you are unable to keep your appointment.

As we receive advanced notice of cancellation, we are able to avoid loss of revenue and misspent employee time, which keeps our overhead down and our fees reasonable. More importantly, we are able to accommodate patients who could have used your appointment time.

Failure to comply with this policy may result in a charge of $50.00 for the missed or cancelled appointment. We understand that situations may arise that make it impossible for you to give 24 hour notice, and each incident will be given individual consideration based on your appointment history. If a charge occurs we will not be able to reappoint you until the balance is cleared.

I have read, and understand this policy. I agree to comply and realize that if I do not I may be charged.

DATE _____ **SIGNATURE_____**

Thank you for coming in. Please take a few moments to review our financial policies and patient bill of rights. If there are any questions, please ask a member of our staff. Our goals include delivering great dental care and helping you have a positive experience with no surprises. The highest compliment our patients can give us is the referral of their friends and family. Thank you for your trust and welcome to our office!

Financial Policies:

- Payment is expected at time of service. **To those without dental insurance** a 7% senior discount **or** 7% military family discount is available.
- We accept Visa, MasterCard, American Express, Discover, debit cards and interest free financing through Care Credit for treatment plans over $500.
- **All treatment appointments over $1500 dollars are reserved with a 10% down payment** -this helps to keep our costs down by reducing cancellations.
- A $50.00 charge is assessed for checks returned for insufficient funds.
- If you have dental insurance and are unfamiliar with it, please ask questions and we will be happy to discuss your policy with you.
- We accept most dental insurances and are contracted providers with many plans. We are referred to as a "preferred" provider in some cases, but not all. Please ask how this may affect your insurance benefit.
- We will send out insurance claim forms as a service to you. The "patient portion" of your bill will be your responsibility.

All patients have rights to the following:

- Be treated fairly and with courtesy in a timely manner
- Receive quality dental care
- Be offered multiple treatment options
- Have all questions answered to their satisfaction
- Be given informed consent prior to dental treatment
- Know approximate cost and time for completion of care
- Understand treatment options including the consequences of no treatment- and to be held responsible for ignoring professional advice.

I have read and understand these policies and agree to comply with them.

Signature of PATIENT, PARENT or LEGAL GUARDIAN_____

DATE_____

Notice of Privacy Practices

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please review.

We are required by law to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of our legal duties and privacy practices with respect to your protected health information.

We may disclose your health care information to:

Other health care providers within our practice for the purpose of treatment, payment or health care operations.

Your insurance provider for the purpose of payment or health care operations.

Comply with Washington State Workers' Compensation Laws.

Notify or assist in notifying a family member, or another person responsible for your care about your medical/dental condition or in the event of an emergency.

Public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and drug administration problems with products and reactions to medications, and reporting disease or infection exposure.

Aid in the course of any administrative or judicial proceeding.

a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Coroners or medical examiners.

Researchers conducting research that has been approved by an Institutional Review Board.

Appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular for military, national security, prisoner and government benefits purposes.

In the event that Ideal Dentistry is sold or merged with another organization, your health information/record will become property of the new owner.

With your Health Information you have the right to:

Request restrictions on certain uses and disclosures of your health information. Please be advised, however, that Ideal Dentistry is not required to agree to the restriction that you requested.

Have your health information received or communicated through an alternative method or sent to an alternative location other that the usual method of communication or delivery upon your request.

Inspect and copy your health information

Request that Ideal Dentistry amend your protected health information. Please be advised however, that Ideal Dentistry is not required to agree to amend your protected health information. If your request to amend your health information has been denied, you will be provided with an explanation of our denial reason(s) and information about how you can disagree with the denial.

Receive an accounting of disclosures of your protected health information made by Ideal Dentistry.

A paper copy of this Notice of Privacy Practices at any time upon request.

Ideal Dentistry reserves the right to amend this notice at any time in the future, and will make the new provisions effective for all information that it maintains. Until such amendment is made, Ideal Dentistry is required by law to comply with this Notice.

Ideal Dentistry is required by law to maintain a the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your health information. If you have any questions about any part of this notice or if you want more information about your privacy rights, please contact: Ideal Dentistry by calling this office at 509-737-8700. If our office manager is not available, you may make an appointment for a personal conference in person or by telephone within 2 working days. If you are not satisfied with the manner in which this office handles your complaint, you may submit a formal complaint to:

DHHS, Office of Civil Rights, 200 Independence Avenue, S.W. , Room 509F, HHH Building, Washington, DC 20201

This notice is effective as of today's date listed below.

I have read the Privacy Notice and understand my rights contained in the notice. By way of my signature, I provide Ideal Dentistry with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

_____

Printed Name

Signature of PATIENT, PARENT or LEGAL GUARDIAN_____

DATE_____