W e l c o m e !

A Northwest Dental **(206) 362-2500**	To help us meet your entire dental care needs, please fill out the following 4 forms completely. If you have any questions, please ask us and we will be happy to help. Thank you.	**16535 5th Avenue NE** **Shoreline, WA 98155**

PATIENT NAME First _____

Middle _____

Last _____

PHONE Home (_____)_____

Work (_____)_____x_____

Cell (_____)_____

Best ph# to reach you at during the day? _____

ADDRESS _____

Apt _____City_____

State_____ Zip _____

BILLING ADDRESS (if different)

_____

Apt_____ City_____

State _____ Zip_____

Patient Date of Birth_____ Sex M / F

Patient Social Security # _____

Driver's Lic. _____State_____

Employer_____

Occupation_____

Marital Status_____

Name of Spouse or Parent if Child

_____

Name of Medical Doctor_____

Phone (_____)_____

Date of last complete physical_____

Former Dentist_____

Date of last comprehensive dental exam_____

Date of last series of x-ray_____

E-mail address _____

Whom may we thank for referring you?

_____

EMERGENCY CONTACT (other than spouse):

Name_____

Relation to patient_____

Phone (_____)_____

PRIMARY DENTAL INSURANCE

Subscriber_____

Subscriber Social Security #_____

Relation to Patient_____Date of Birth_____

Employer_____

Human Resources/Benefit Coordinator:

Name_____

Telephone (_____)_____x_____

Dental Insurance Co_____

Customer Service Telephone (_____)_____

SECONDARY DENTAL INSURANCE

Subscriber_____

Subscriber Social Security #_____

Relation to Patient_____Date of Birth_____

Employer_____

Human Resources/Benefit Coordinator:

Name_____

Telephone (_____)_____x_____

Dental Insurance Co_____

Customer Service Telephone (_____)_____

SIGNATURE:	**DATE:**
SIGNATURE:	**DATE:**

Dental Health History

Please check any questions that you would answer "YES"

- ❑ Are you apprehensive about dental treatment?
- ❑ Do you wear dentures?
- ❑ Does food catch between your teeth?
- ❑ Are your teeth sensitive when chewing?
- ❑ Are your teeth sensitive to cold?
- ❑ Are your teeth sensitive to hot?
- ❑ Are your teeth sensitive to sweet?
- ❑ Do your gums bleed easily?
- ❑ Do your gums feel swollen or tender?
- ❑ Have you ever been treated for gum disease?

How often do you brush?_____

How often do you floss? _____

- ❑ Do you grind or clench your teeth?
- ❑ Do you have earaches or pain in front of the ears?
- ❑ Do you have a temporomandibular disorder (TMJ)?
- ❑ Are you unable to open your mouth wide?
- ❑ Have you had a trauma to the jaw?
- ❑ Are you a habitual gum-chewer?
- ❑ Do you take fluoride supplements?
- ❑ Are you unhappy with the appearance of your teeth?

Medical Health History

Heart Problems

- ❑ Chest pain
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart murmur
- ❑ Heart valve problem
- ❑ Rheumatic fever
- ❑ Artificial heart valve
- ❑ Pacemaker

M.D. Required PREMEDICATION
Reason:

Nervous system

- ❑ Stroke
- ❑ Headaches
- ❑ Seizures/Epilepsy
- ❑ Psychiatric Treatment

Respiratory

- ❑ Tuberculosis
- ❑ Emphysema
- ❑ Asthma
- ❑ Sinus problem
- ❑ Difficulty breathing while lying down
- ❑ Hay fever

Allergies Are you allergic or have you ever had an adverse reaction to any of the following?

- ❑ Local anesthetics~Novocain
- ❑ Penicillin
- ❑ Sulfa Drugs
- ❑ Other antibiotics~please specify:

  _____
- ❑ Aspirin, acetaminophen, or ibuprofen
- ❑ Codeine, Demerol, or other narcotics
- ❑ Reaction to metal
- ❑ Latex
- ❑ Other allergies~please specify:

  _____

Blood Problems

- ❑ Easy bruising
- ❑ Frequent nose bleeding
- ❑ Abnormal bleeding
- ❑ Blood disease~anemia
- ❑ Ever had blood transfusion?

Endocrine

- ❑ Diabetes
- ❑ Family history of diabetes
- ❑ Thyroid problems
- ❑ Taken Fosamax, Zometa, **Aredia**, or Actonel?

Bone/joint problems

- ❑ Arthritis
- ❑ Back or neck pain
- ❑ Joint replacement

Other

- ❑ Hepatitis: Type_____
- ❑ Ulcer
- ❑ Kidney or bladder problem
- ❑ Venereal disease
- ❑ History of alcohol or drug abuse
- ❑ Do you smoke/use tobacco in any form?

  If yes, how much?_____
- ❑ Radiation therapy
- ❑ Chemotherapy
- ❑ Tumors/growth
- ❑ Cancer
- ❑ HIV+
- ❑ AIDS

Women

- ❑ Taking contraceptives
- ❑ PREGNANT: delivery date_____
- ❑ Nursing

Please list all medications you are currently taking:_____

_____

SIGNATURE:	**DATE:**

A Northwest Dental Financial Agreement

Thank you for choosing our office for your dental needs. We realize that every person's financial situation is different. For this reason, we have worked hard to provide a variety of payment options to help you receive the dental care you need and deserve that allows you to enjoy a healthy, beautiful smile with respect to your budget.

Optional Payment Terms:

1. Full Pay Cash Discount: We offer a 5% accounting courtesy for all treatment over $300, that is paid in full (cash or check) at the time of service.
2. Major Service 2 Payment Option: We offer a two-payment option for Crown, Bridge, and Denture treatment. We ask that you pay one-half of your co-payment at the first appointment and the second half at the seat date appointment.
3. Credit Card Payment Option: We allow (with a signed agreement form), a Credit Card Payment option, this allows you to make three equal installments by credit card. One-third payment is due at the first appointment, one-third is due thirty days later, and the remaining one-third is due sixty days from the initial appointment. Our office personnel will charge these payments to your credit card on the due dates.
4. Term Loan: By arrangement with Citi Health Card or Dental Fee Plan, we offer our patients, upon approval, an interest-free term loan (up to 12 months) with no down payment, no annual fee, and no prepayment penalty. Please ask for an application.

To maintain the practice operations and to prevent potential misunderstandings, we ask patients to accept and adhere to financial arrangements regarding their dental treatment. Payments are expected at the time services are rendered. We accept cash, checks, ATM cards, and all major credit cards.

Broken appointments: This time that has been reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least 48 hours notice to avoid a $40.00 cancellation fee (emergencies are an exception).

For Our Patients with Dental Insurance

As a courtesy to you we will gladly process your insurance claim forms. We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, final determination is made by your insurance company once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

Insured Party's Signature: _____

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1 1/2% per month interest. I am responsible for all collection costs incurred by the dental office and on a returned check, a fee of $30.00.

Signature _____ **Date** _____

STATEMENT OF PRIVACY PRACTICES

A Northwest Dental
16535 - 5th Avenue NE
Shoreline, Washington
206-362-2500

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

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.

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.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

A Northwest Dental

A Northwest Dental
16535 - 5th Avenue NE
Shoreline, Washington 98155
206-362-2500

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 A Northwest Dental. 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.

A Northwest Dental 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):