SEATTLE DENTAL Co

NOTICE OF PRIVACY POLICIES

Health Insurance Portability Accountability Act (HIPAA), 1996
http://www.hhs.gov/ocr/hipaa/finalreg.html

Name: _____ Phone: _____

Address: _____

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

CONSENT FOR TREATMENT: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

YOUR RIGHTS
You have the right to have access and/or copies of your PHI records at any time. You have the right to request additional restrictions on your PHI, and we will do so unless legally bound otherwise. You have the right to refuse to sign the consent form, or to rescind your consent.

_____
Signature

SEATTLE DENTAL Co

ABOUT YOU

Today's Date: _____

Name: _____
LAST FIRST MI MR MRS MS DR

I prefer to be called: _____

SS #: _____

Birthdate: _____ Age: ____ ☐ Male ☐ Female ☐ Gender Neutral

Home Address: _____
APT/CONDO #:

_____
CITY STATE ZIP

Cell #: _____

E-mail Address: _____

How do you prefer to be contacted? ☐ E-Mail ☐ Phone ☐ Text

Employer: _____

Occupation: _____

☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Other family members seen by us: _____

Previous / Present Dentist: _____
(Please Circle)

Last Visit Date: _____

How did you find out about us? ☐ Friend ☐ Google ☐ ZocDoc ☐ Yelp ☐ Facebook ☐ Other

Whom may we Thank for referring you? _____

INSURANCE COVERAGE

Primary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

Secondary

Dental Coverage: ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's ID #: _____

Insured's Employer: _____

SPOUSE INFORMATION

His / Her Name: _____

Employer: _____

SS #: _____ Birthdate: _____

Person Responsible for Account: _____

Cell: _____ Employer: _____

Billing Address: _____

Relation: _____ SS #: _____

EMERGENCY CONTACT

In the event of an emergency, is there someone who lives near you that we should contact?

His / Her Name: _____ Relation: _____

Wk #: _____ Cell #: _____

CONTINUED ON BACK

MEDICAL HISTORY

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Phone #: _____ Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Your current physical health is: ☐ Good ☐ Fair ☐ Poor

Are you taking any prescription/over-the-counter or herbal supplement drugs? ☐ Yes ☐ No

Please list each one: _____

_____

Have you ever taken Fosamax, or any other bisphosphonate? ☐ Yes ☐ No

For Women: Are you pregnant? ☐ Yes ☐ No Week #: _____

Are you nursing? ☐ Yes ☐ No

Have you ever had any of the following diseases or medical problems?

- ☐ Abnormal Bleeding
- ☐ Alcohol / Drug Abuse
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma
- ☐ Blood Transfusion
- ☐ Cancer/Chemotherapy
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
- ☐ Difficulty Breathing
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fainting Spells
- ☐ Frequent Headaches
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ Herpes / Fever Blisters
- ☐ High Blood Pressure
- ☐ HIV+ / AIDS
- ☐ Hospitalized for Any Reason
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Psychiatric Conditions
- ☐ Radiation Treatment
- ☐ Rheumatic / Scarlet Fever
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease / Traits
- ☐ Sinus Problems
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis (TB)
- ☐ Ulcers
- ☐ Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

_____

Are you allergic to any of the following?

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetics
- ☐ Erythromycin
- ☐ Jewelry
- ☐ Latex
- ☐ Metals
- ☐ Penicillin
- ☐ Tetracycline

Please list any other drugs/materials that you are allergic to:

_____

_____

DENTAL HISTORY

Why have you come to the dentist today?

_____

_____

_____

Do you require antibiotics before dental treatment? ☐ Yes ☐ No

Are you currently in pain? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

Have you ever had a serious / difficult problem associated with any previous dental work? ☐ Yes ☐ No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Your current dental health is: ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No

Would you like whiter teeth? ☐ Yes ☐ No Fresher breath? ☐ Yes ☐ No

How many times a week do you floss? a day do you brush?

Type of bristles? ☐ Soft ☐ Medium ☐ Hard

Do you smoke or use tobacco in any other form? ☐ Yes ☐ No

I understand that the information that I have given today 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 in my medical status.

I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____ Date _____

Signature

INTERNAL USE

I verbally reviewed the medical / dental information above with the patient named herein. Initials: _____ Date: _____

Doctor's Comments: _____

Patient Name

SLEEP DISORDER

Patient Email

• Over 18 million Americans suffer from sleep apnea
• People with sleep apnea are 3 times more likely to be involved in motor vehicle accidents
• 90% of sleep apnea patients have not been diagnosed

Do you snore? ☐ Yes ☐ No

Do you have high blood pressure? ☐ Yes ☐ No

Have you gained weight and find it difficult to lose? ☐ Yes ☐ No

Do you have unexplained awakenings from sleep? ☐ Yes ☐ No

Do you awaken from sleep gasping or choking? ☐ Yes ☐ No

Do you often lay in bed unable to fall asleep? ☐ Yes ☐ No

Do you notice frequent twitching or jerking of legs while asleep? ☐ Yes ☐ No

Do you feel sleep is not refreshing or restful? ☐ Yes ☐ No

Do you have a headache upon waking in the morning? ☐ Yes ☐ No

Do you wake up during the night and are unable to fall back asleep? ☐ Yes ☐ No

Do you feel fatigued or find it difficult to stay awake during the day? ☐ Yes ☐ No

******If you have answered YES to any one of the above questions please consult with your doctor******

Prior Diagnosis:

Have you been previously diagnosed with sleep apnea? ☐ Yes ☐ No

If yes, when were you diagnosed approximately? _____

Were you put on CPAP therapy for treatment? ☐ Yes ☐ No

Are you still using your CPAP every night? ☐ Yes ☐ No

Insurance:

Do you have medical insurance? ☐ Yes ☐ No

If yes, what type? ☐ HMO ☐ PPO ☐ Other

Other: _____

Epworth Sleepiness Scale

How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? This refers to your usual way of life in recent times. Even if you have not done some of these things recently try to work out how they would have affected you. Use the following scale to choose the most appropriate number for each situation.

Please answer with a 0 to 3

0= Never doze off, 1= Slight chance of dozing, 2= Moderate chance of dozing, 3= High chance of dozing

Sitting and reading ☐ 0 ☐ 1 ☐ 2 ☐ 3

Watching T.V. ☐ 0 ☐ 1 ☐ 2 ☐ 3

Sitting inactive in a public place ☐ 0 ☐ 1 ☐ 2 ☐ 3

As a passenger in a car for an hour without a break ☐ 0 ☐ 1 ☐ 2 ☐ 3

Laying down to rest in the afternoon ☐ 0 ☐ 1 ☐ 2 ☐ 3

Sitting and talking with someone ☐ 0 ☐ 1 ☐ 2 ☐ 3

Sitting quietly after lunch without alcohol ☐ 0 ☐ 1 ☐ 2 ☐ 3

In a car, while stopped for a few minutes in traffic ☐ 0 ☐ 1 ☐ 2 ☐ 3

Doctor _____ Date _____

Phone _____ Fax _____

SEATTLE DENTAL CO

DR. BELINDA SONG, D.D.S. | DR. AMANDA GUERRERO D.D.S.

Date: _____

To: _____
Doctor/Office

I am writing to authorize the release of my dental records to the office of Seattle Dental Co. Such records include, but are not limited to, patient forms, chart notes, radiographs, patient photographs, specialist correspondence and outside records.

Please provide these records to:

Seattle Dental Co.
100 W. Harrison St.
Ste. #150, North Tower
Seattle, WA 98119
(206) 284 - 4412

hello@seattledentalco.com

Sincerely,

Sign: _____

Print: _____

SEATTLE DENTAL Co

DR. BELINDA SONG, D.D.S. | DR. AMANDA GUERRERO D.D.S.

I,_____, authorize the release of my information of
(Print Patient / Guardian Name)

_____, including the diagnosis, records, examination and treatment
(PATIENT NAME)
rendered to the above listed patient, ledger and billing, and claims information.

This information may be released to (check one):

☐ Spouse_____

☐ Child(ren)_____

☐ Other_____

☐ Information is not to be release to anyone. (Initial here) _____

In further consideration for this, Seattle Dental Co. agrees to the same stipulations. This **Release of Information** will remain in effect until terminated by me in writing.

<u>Messages and communication from our office</u>

If we are unable to speak directly to you concerning matters pertaining to your care, please check one of the following preferences:

☐ you may leave a detailed voice message

☐ please leave a message asking me to return your call

☐ other _____

The best phone number to reach me at is: _____

Signed: _____ **Date** ____/____/_____

SEATTLE DENTAL Co

Financial Policy

Our primary goal is to not allow the cost of treatment to prevent you from benefiting from the quality care you need or desire. In our office, we strive to maximize your insurance benefits and make any remaining balance easily affordable.

Our fees are based on the quality of materials we use and the time, effort and skill required in performing your needed treatment. We charge what is usual and customary for our area. Our financial coordinator will assist you with your benefit eligibility before treatment to help you calculate your costs and maximize your insurance. We will be sensitive to your financial circumstances and do everything possible to help you achieve the best oral health.

Payment for services is due at the time services are rendered.

We accept the following forms of payment: Check, Visa, MasterCard and Discover.

Your insurance policy is an agreement between you and your insurance company. We are happy to submit claims and necessary documentation to see that you receive the full benefits of your coverage. However, we cannot guarantee any estimated coverage. Ultimately, you are responsible for the full cost of treatment regardless of your insurance company's determination of coverage or acceptable fees.

Rescheduling Policy

Our practice is dedicated to quality care and exceptional service. Appointments are reserved exclusively for you. Our team spends an extensive amount of time preparing for your visit, and we often have waitlists for available appointment times. If you find that you must change your appointment, we request that you contact our office during our business hours and provide 48 hours' notice so that we may accommodate others.

If proper notice is not received, a fee of $55 will be charged for your cancelled appointment.

Print: _____

Sign: _____ Date: _____