



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



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. It is your responsibility to keep track of your annual maximum and available benefits. 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 (Mon-Thurs from 8 AM to 5 PM) and provide 48 business 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: _____



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:
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 #:

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?

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

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

Are you allergic to any of the following?

- | | | |
|---|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Erythromycin | <input type="checkbox"/> Metals |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Penicillin |
| <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Latex | <input type="checkbox"/> 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: _____
Name of Previous Dentist / Dental 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.

To protect your privacy, we do not communicate any of your information to others (including answering billing questions, treatment plans, or questions about insurance information) unless given permission to do so. If you would like to specify individuals whom we may speak to regarding your information (or your child's/dependent's information), please specify below.

I, _____, authorize the release of information for
(PATIENT NAME (or Guardian Name if patient is a dependent))

_____, 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 released 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.

Messages and communication from our office

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 ____/____/____

