PATIENT MEDICAL INFORMATION ***Patient Name*** ________________________________

Name of Physician ______________________ *Telephone #* __________________ *Last Exam* _______________

Are you under medical care at this time? ____

(If yes to any of the following please explain)

Have you been hospitalized within the last 5 years? ____

Are you taking any medications, including non-prescribed medications? ________________________________

____

Are you wearing contact lenses? ________ *Do you use any controlled substances?* ______________________

Do you use tobacco products? ______ *What type?* ________________ *How often?*___________

Have you ever taken Phen-Fen/Redux? _______ *When?* ______ *For how Long?* ____________

Are you or have you ever taken? Fosamax _____ *Actenol* ______ *Zometa* _____ *Aredia* _____ *Boniva* _____

WOMEN ONLY: *Are you pregnant? (or think you may be)* _________ *How far along are you?* ___________

Are you nursing? ________ *Are you taking oral contraceptives?* _________

ALLERGIES: Are you allergic or have any reaction to the following:

Local Anesthetic (Novocain) _________ *Penicillin or any other Antibiotics* _____________________________

*Latex Rubber*____ *Aspirin* _____ *Barbituates* ______ *Sedatives* ______ *Sulfa Drugs* ______ *Codeine* _______

Any Metals (Nickel, mercury, etc) ____________ *other* ____

HAVE YOU HAD ANY OF THE FOLLOWING: Please check those that apply

____ *AIDS*	____ *Glaucoma*	____ *Radiation Treatment*
____ *Anemia*	____ *Heart Murmur*	____ *Respiratory Problems*
____ *Arthritis*	____ *Heart Disease*	____ *Rheumatic Fever*
____ *Artificial Joints*	____ *Head Injuries*	____ *Rheumatism*
____ *Asthma*	____ *Hepatitis*	____ *Sinus Problems*
____ *Angina*	____ *High Blood Pressure*	____ *Stomach Problems/Ulcers*
____ *Cancer*	____ *Heart Attack*	____ *Stroke*
____ *Cardiac Pacemaker*	____ *Jaundice*	____ *Sexually Transmitted Diseases*
____ *Chest Pains*	____ *Kidney Disease*	____ *Tuberculosis*
____ *Diabetes*	____ *Leukemia*	____ *Tumors*
____ *Dizziness*	____ *Low Blood Pressure*	____ *Thyroid Problems*
____ *Epilepsy*	____ *Liver Disease*	*Other:*
____ *Excessive Bleeding*	____ *Mental Disorders*	_________________________
____ *Emphysema*	____ *Mitral Prolapse Valve*	_________________________
____ *Fainting*	____ *Nervous Disorders*	_________________________

DENTAL HISTORY:

1. *Do you bleed while brushing or flossing?* _______
2. *Are your teeth sensitive to temperature?* _________
3. *Are your teeth sensitive to sweets?* _________
4. *Do you feel pain on any of your teeth?*_______
5. *Do you have any sores in or near your mouth?* _____
6. *Have you ever had any head, neck or jaw injuries?* _____
7. *Do you bite your lips or cheeks frequently?* _______
8. *Do you wear dentures or partials?* ______
9. *Are you nervous about dental treatment?* ______
10. *Do you have difficulty chewing?*________
11. *Have you ever had orthodontic treatment?* _____
12. *Do you like your smile?* ________

I certify that to the best of my knowledge the information provided is accurate and correct. It is my responsibility to notify my doctor in case of any changes in my health history. I give consent for treatment.

____ ___________________________

Patient (Guardian if under age 18) *(Date)*

____

Reviewed By *Date*

PATIENT INFORMATION

Patient Name: ____ Date: _________________
Last First MI (Preferred Name)
Address: ____ Apt # ___________________
Street City State Zip
*Phone: (**Cell**) __________________ (W) ________________ (Home) ______________ **E-mail**____________________*

Social Security # ____ Date of Birth _______/_______/_______ Gender M / F

Occupation: ____________________________________ Employer: ____

Address: ____ Telephone: _____________________ Extension: _______

Emergency Contact: ___________________________ Relationship: _________ Telephone:___________________________

Whom may we thank for referring you to our practice? ____

If PATIENT is under 18 please write parents name(s): ____
(Please write last name if different from patients)

FINANCIAL INFORMATION (PLEASE DO NOT DUPLICATE ANY INFORMATION)

Name of responsible individual for account:____
Last First MI
Address: ____ Apt # __________
Street City State Zip
Phone: (Cell)_________________ (W) _______________ (Home) ________________ E-Mail____________________

Social Security # ___________________________ Date of Birth _______/_______/_______ Gender M / F

INSURANCE INFORMATION
(PRIMARY)

Name of Subscriber:____ Date of Birth _______/_______/_______

Patient relationship to insured: _____________Social Security # or INS ID # ____

Name of Insurance Company: _____________________________________ Employer: ________________________________

(SECONDARY)

Name of Subscriber: ____ Date of Birth _______/_______/_______

Patient relationship to insured: _____________Social Security # or Ins ID # ____

Name of Insurance Company: ________________________________ Employer: ______________________________________

Penny Creek Family and Cosmetic Dentistry
3922 148th ST SE # 201
Mill Creek, WA 98012
425-337-7300

FINANCIAL POLICY /Agreement

We are committed to providing you with the highest quality of dental care utilizing only the best materials and technology available. In our efforts to do so, we have formulated the following financial policy. We value our patients and have worked hard to provide several options to meet your needs.

DENTAL INSURANCE

Penny Creek Family & Cosmetic Dentistry is happy to partner with our patients who are covered by dental insurance by billing the insurance for you. However, it is your responsibility to inform us when your policy changes so we can bill the correct carrier. We ask that **YOU read your policy thoroughly** so that you are fully aware of the benefits provided and the limitations imposed. Please call your insurance company if you have any questions concerning your plan. Please understand that our responsibility is to provide you with **Superior Dental Care** and the treatment that best meets your needs.

It is our goal for patients to clearly understand their treatment needs as well as their financial responsibility before treatment begins. Estimated patient portions are due at time of service. We do our best to **estimate** your patient portion prior to your appointment. These estimates are based on the outline given by your insurance plan. Please note that these are **estimates** only. As stated by all insurances companies, there is not a guarantee of payment until the actual claim is processed. Due to policy differences and clauses you may owe more than we **estimate**. If your insurance company pays more than the estimate we will issue a prompt refund.

Outstanding insurance claims over 90 days, become the patient's responsibility. All incurred charges are ultimately the responsibility of the patient.
We are unable to carry "patient" balances over 90 days in the office. Therefore, all over due balances of 90 days or more are sent out of the office for collection.

PAYMENT OPTIONS:

We are pleased to offer 3 payment options for our patients:

1. We gladly accept Visa, MasterCard and American Express for your convenience.
2. Care Credit – A special No interest financing option is provided by our Doctors.
3. Limited in house financing on certain types of treatment: ½ at start of treatment with balance due at completion.

All Estimated Patient portions are due at time of service.

Patient Signature: ____________________________________ Date: _______________

Acknowledgement of Privacy Practices

Penny Creek Family & Cosmetic Dentistry

3922 148th Street SE, #201

Mill Creek, WA 98012

425-337-7300

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices.* I understand that my dental provider has the right to change the *Notice of Privacy practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used and disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: ___________________________________ **Date: ____________________________________**

Signature: _______________________________________

Relationship to Patient: _____________________________

Dependent family members are also covered by this acknowledgement.

Additional Disclosure Authority:

Any member of my immediate family: Yes____ No____

Spouse only: Yes ____No____

Other: Yes_____No _____Specify____________________

PennyCreek Family and Cosmetic Dentistry
3922 148th ST SE # 201
MillCreek, WA 98012
425-337-7300

Confirmation and Scheduling Policies

Please take a few minutes to carefully review our policy on confirmation and scheduling and sign below.

When you schedule an appointment, we trust you to be responsible for remembering and keeping it. As a courtesy, we will do our best to confirm your appointment one to two days prior. Please be sure we have your correct phone numbers and/or email.

We understand that schedules change. If you find you are unable to keep your scheduled appointment, we respectfully request ***72*** *hours advance notice.* ***48*** *hours notice is* ***required*** *to avoid a cancellation charge. Failed appointments or "no-show" appointments will be charged $50.00 per one-half hour of scheduled operatory time. Appointments cancelled or re-scheduled without 48 hours notice will be charged $25.00 per one-half hour of operatory time.*

Saturday Appointments:
Saturday appointments are some of the most popular and are often booked months in advance. Saturday appointments require ***48*** *hours notice for cancellation and re-scheduling. Cancelled or re-scheduled appointments on Saturdays without 48 hours notice will be charged* ***$100.00.***

We work hard in consideration of your time and schedule. Thank you in advance for your understanding and cooperation.

*Patient Signature:*__________________________ *Date:*___________________

Notice of Privacy Practices

Penny Creek Family & Cosmetic Dentistry

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose such information.

Without specific authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

Unless you request otherwise, we may use or disclose your health information to a family member, friend or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and leaving messages at your home or work. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that request, exept to the extent that we have already taken actions relying on your authorization.

You have the following rights:

- The right to request restrictions on certain uses and disclosures of protected health information. We are, however, not required to agree to a requested restriction. if we do agree, we must abide by it.
- The right to request to receive confidential communications of protected health information by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information, outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this agreement upon request.

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

You have the right to file a formal complaint with us or with the Department of health & Human Services, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about HIPAA or to file a complaint, please contact:

The U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue S.W., Washington D.C. 20201, (877) 696-6775

For more information about our Privacy Practices, please contact:

Penny Creek Family & Cosmetic Dentistry, 3922 148th Street SE, #201, Mill Creek, WA 98012, (425) 337-7300