Pinewood FAMILY DENTAL

3701 88th St. NE Suite D Marysville, WA 98270
www.PinewoodFamilyDental.com | pinewoodfamilydental@gmail.com

Today's Date ____/____/_____

## Patient Information

Patient name _____ Preferred Name_____

How did you hear about us? _____ Friends name (if applicable) _____

SS# _____ Gender ___M___F Birthdate ____/_____/_____

Email address _____ Home Phone_____

Cell_____ Work Phone_____

Billing Address_____

Drivers License #_____

When was your last dental appointment?_____

Why did you leave your last dentist?_____

Are you nervous about going to the dentist? _____Yes_____No_____Somewhat

Emergency Contact_____ Phone Number_____

## Responsible Party

Name of the person responsible for this account (if someone other than yourself)_____

Relationship_____ SS#_____ Birthdate ____/____/_____

Home Phone_____ Cell _____ Email _____

Address _____

Employer _____ Work Phone _____

## Insurance Information

Subscriber's Name _____ Relationship_____

SS# _____ Birthdate _____/_____/_____ Employer _____

Insurance Company _____ Group # _____

Have you used this insurance at a dental practice before? ____YES _____ NO

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# Health Assessment

1. Are any of your teeth sensitive to: __ Cold __ Heat __ Sweets __Biting Pressure
   Comments: _____
2. Does your jaw ever feel sore? ___yes ___no
3. Name of primary care physician: _____ Date of last visit: _____
   Reason for your last visit:_____
4. Have you ever been hospitalized ___yes ___no If yes, please describe:_____
5. Have you taken any medicine during the past two years, including prescriptions, over the counter meds, vitamins and herbal supplements? _____yes _____no If yes, please list: _____
   _____
6. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics or any other drugs? __yes ___no
   If yes, please list: _____
7. Have you ever had a reaction to local anesthetics? ___yes ____no
8. Do you have a reaction to metal jewelry or latex ___yes ____ no If yes, please describe_____
9. Have you ever had any excessive bleeding requiring special treatment? ___yes ____no
10. WOMEN: Are you pregnant or are you trying to become pregnant? ___yes ___no Breast feeding? ___yes ___ no
11. Do you smoke or chew tobacco products? ___yes ___ no If yes, how long have you smoked/chewed? _____

**Please check any of the following, which you have had or have at present:**

| | | | | |
|---|---|---|---|---|
| ___Autoimmune Disease | ___ Radiation | ___ Diabetes | ___ Rheumatic fever | ___Allergies or Hives |
| ___ Head Injuries | ___ Liver Disease | ___ Epilepsy | ___Anemia | ___ Mental Disorders |
| ___ Rheumatism | ___ Sinus Problems | ___Arthritis | ___ Heart Murmur | ___ Nervous Disorders |
| ___ Stomach Problems | ___Artificial Joints | ___ Hepatitis | ___ Pacemaker | ___ High blood pressure |
| ___Asthma | ___Fainting | ___ Glaucoma | ___ Blood Disease | ___Penicillin Allergy |
| ___ Stroke | ___ Tuberculosis | ___ Cancer | ___Jaundice | ___Pre-med required |
| ___ Kidney Disease | ___ Thyroid Disease | ___Ulcers | ___Tumor Growths | ___ Heart Disease |
| ___ Venereal Disease | ___Hay Fever | ___Dizziness | ___ Respiratory problems | |

Do you have any medical condition or problem not listed above? ___ yes ___ no

If yes, please list: _____

**To the best of my knowledge, all of these answers are true and correct. If I have any changes in my health, I will inform Pinewood Family Dental at or prior to my next appointment.**

| _____ | _____ | _____ |
|---|---|---|
| Patient name | Signature of Patient or Guardian | Date |

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# NOTICE OF PRIVACY PRACTICES
## Pinewood Family Dental

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

### OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us at our office.

### USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment**: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment**: We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations**: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing, or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care**: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services**: We will NOT use your health information for marketing communications without your written authorization.

**Required by Law**: We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect**: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

**National Security**: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

**Appointment Reminders**: We may use or disclose your health information to provide you with appointment reminders (such as voice-mail messages, postcards, or letters.)

## PATIENT RIGHTS

**Access**: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice.)

**Disclosure Accounting**: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

**Restrictions**: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

**Alternative Communication**: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

**Amendment**: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

**Electronic Notice**: If you receive this Notice on our Web site or by electronic mail(e-mail), you are entitled to receive this Notice in written form.

## QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, You may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.


**Contact:** **Pinewood Family Dental**

**Telephone:** **360-229-6739**

**E-Mail:** **pinewoodfamilydental@gmail.com**

**Address:** **3701 88th St. NE Suite D**

**Marysville, WA 98270**

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# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received and understand the practice's Notice of Privacy Practices. This notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices and to make changes regarding all protected health information resident at, or controlled by this practice. If changes to the policy occur, this practice will provide me a revised Notice of Privacy Practices upon request.

Please Print Name _____

Signature _____ Date _____
**Relationship to patient if signed by a personal representative of patient: _____

## Additional Disclosure Authorization

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize the disclosure of my protected health information to the individuals or entities indicated below.

Any member of my immediate family ___ YES ___ NO
Spouse only ___YES ___ NO
Other (Name and relationship to patient): _____

Signature _____ Date _____
**Relationship to patient if signed by a personal representative of patient: _____

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# Financial Policy

In our continued commitment to provide the highest quality of dental care to all our patients and to have those services affordable, we are pleased to offer you these financial options and guidelines for payment:

- If you have insurance, we will gladly process your claims. We do require that you pay all estimated patient portions when services are rendered.
- Every effort will be made to help you with your insurance. The estimated insurance coverage is not a guarantee of payment and the insurance company, not our office, determines the dental benefits you receive. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage. ·
- For our patients without dental insurance dental savings plan is a good alternative. Please inquire for details
- We accept Visa, MasterCard, Discover, personal checks, debit cards and cash.
- Financing is available through Care Credit, which offers interest free payment options for large treatment plans. Ask us for an application.
- If you pay by check and your check is returned, there will be a $40.00 returned check fee charged to your account. You will be notified immediately, and the balance will be due within 5 business days.
- CANCELLATION POLICY
    - Any appointment that is missed or not cancelled within 2 business days (Business days are Monday through Friday) of the appointment will be subject to a charge of $50.00 for first occurrence. Future missed or cancelled appointments may require a deposit prior to rescheduling in addition to the missed/late cancel fee. No further appointments will be made until the fee is paid.

I have read, understood and agreed to all of the above Financial Policies of Pinewood Family Dental. I understand that treatment cannot begin until this form is signed and agreed to.

Signature of Patient (Parent if under 18) _____

Printed Name _____ Date _____