First Hill Dental Center

ABOUT YOU

Today's Date: _____/_____/_____

Patient Name: _____
LAST FIRST MI

What do you preferred to be called: _____

Date of Birth: _____/____/_____ Age: _____ SS#_____

Mailing Address: _____

_____
CITY STATE ZIP

Home Phone:_____

Work Phone:_____ EXT:_____

Cell Phone: _____

Email: _____

Referred By: _____

Employer: _____

Occupation: _____

Status: Married_____ Single_____Divorced_____

Spouse/Partner's Name: _____

ACCOUNT INFORMATION
PERSON ULTIMATELY RESPONSIBLE FOR THIS ACCOUNT

Name: _____

Relation: _____

Alternate Billing Address: _____

_____
CITY STATE ZIP

SS#_____ Cell Phone:_____

Work Phone:_____ EXT:_____

METHODS OF PAYMENT
CASH, CHECK, MC, VISA, AMEX, DISCOVER, CARE CREDIT

_____, I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand that I, not my insurance company, am ultimately FINACIALLY RESPONSIBLE for payment in full AT THE TIME OF SERVICE FOR ALL SERVICES RENDERED.
Initials

INSURANCE INFO

Primary Dental Insurance:

Ins. Company Name:_____

Ins. Co. Address:_____

_____
CITY STATE ZIP

Ins. Co. Phone Number: _____

Insured's SS#:_____

Insured's Name: _____

Relation: _____ Date of Birth: ____/_____/____

Insured's Employer: _____

Secondary Dental Insurance:

Ins. Company Name: _____

Ins. Co. Address: _____

_____
CITY STATE ZIP

Ins. Co. Phone Number: _____

Insured's SS#: _____

Insured's Name:_____

Relation: _____ Date of Birth: ____/___/___

Insured's Employer: _____

IN THE EVENT OF EMERGENCY

Who should we contact:_____

Relation: _____

Home Phone Number: _____

Work Phone Number: _____ EXT _____

Cell Phone Number: _____

Your Medical Doctor: _____

Your Medical Doctor's Phone Number: _____

THANK YOU!

HIPPA

NOTICE OF PRIVACY PRACTICES FOR THE OFFICE OF :

FIRST HILL DENTAL CENTER

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.

If you have any questions about this notice, please contact:

FIRST HILL DENTAL CENTER
206-323-3830

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by health care providers you consult with by telephone (when your regular health care provider from our office is not available) who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care and services you receive at this office. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

FOR TREATMENT

We may use health information about you to provide you with medical treatment of services. We may disclose health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health. For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be a part of your medical care outside this office and may require information about you that we have.

FOR PAYMENT

We may use and disclose health information about you so that the treatment and services you receive at this office may be billed to and payment may be collected from you, an insurance company or third party. For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval, or to determine whether your plan will cover the treatment.

FOR HEALTH CARE OPERATIONS

We may use and disclose health information about you in order to run the office and make sure that you and our other patients receive quality care. For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should office, how we can become more efficient, or whether certain new treatments are effective.

APPOINTMENT REMINDERS

We may contact you as a reminder that you have an appointment for treatment or medical care at the office. We use this information to provide to you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for First Hill Dental Center in the administration of your benefits in accordance with HIPPA. These third parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for First Hill Dental Center in the administration of your benefits. Our affiliates do not sell, share or rent our users' personally identifiable information unless required by law, do not send any email or other communications without user permission, and do not spam. By signing this form you agree to allow Demandforce to use this information in providing my services.

TREATMENT ALTERNATIVES

We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

HEALTH-RELATED PRODUCTS AND SERVICES

We may tell you about health-related products or services that may be of interest to you. Please notify us if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing that you do not wish to receive such communications, we will not use or disclose your information for these purposes.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

HIPPA

TO AVERT A SERIOUS THREAT TO HEALTH OR SAFETY

We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

REQUIRED BY LAW

We will disclose health information about you when required to do so by federal, state or local law.

MILITARY, VETERANS, NATIONAL SECURITY AND INTELLEGENCE

If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

WORKERS COMPESNATION

We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

PUBLIC HEALTH RISKS

We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

HEALTH OVERISGHT ACTIVITIES

We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

LAWSUITS AND DISPUTES

If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

LAW ENFORCEMENT

We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

CORONERS, MEDICAL EXAMINERS AND FUNERAL DIRECTORS

We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determined cause of death.

INFORMATION NOT PERSONALLY IDENTIFIABLE

We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.

FAMILY AND FRIENDS

We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room during treatment or while treatment is discussed.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written authorization. If you give us authorization to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke that authorization, we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission. If we have HIV or substance abuse information about you, we cannot release that information without a special, signed, written authorization from you that complies with the law governing HIV or substance abuse records.

YOUR RIGHTS REGARDING HEALTHI NFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

RIGHT TO INSPECT AND COPY

You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to First Hill Dental Center in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

RIGHT TO AMEND

If you believe health information we have about you is incorrect of incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office. We may deny your request for an amendment if

HIPPA

it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

a.) We did not create, unless the person or entity that created the information is no longer available to make the amendment.

b.) Is not part of the health information that we keep.

c.) You would not be permitted to inspect and copy.

d.) Is accurate and complete.

RIGHT TO AN ACCOUTING OF DISCLOSURES

You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment and health care operations. To obtain this list, you must submit your request in writing to: FIRST HILL DENTAL CENTER

It must state a time period, which may not be longer than five years and may not include dates before October 1, 2011. Your request should indicate in what form you want the list (for example, on paper, electronically). We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

RIGHT TO REQUEST RESTRICTIONS

You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

WE ARE NOT REQUUIRED TO AGREE TO YOUR REQUEST

We may not (and are not required to) agree to your restrictions with one exception: If you pay in full (out of pocket) for a service you receive from us, and you request that we not submit the claim for this service to your health insurer or health plan for reimbursement, we must honor that request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to contacted.

RIGHT TO A PAPER COPY OF THIS NOTICE

You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. To obtain such a copy, contact: FIRST HILL DENTAL CENTER.

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or change notice effected for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect. To request restrictions, you may complete and submit a Request For Restricting Uses and Disclosures and Confidential Communications Form Information to: FIRST HILL DENTAL CENTER.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you may complete and submit the Requests For Restricting Uses and Disclosures and Confidential Communications to: FIRST HILL DENTAL CENTER

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of Department of Health and Human Services. To file a complaint with our office, contact:

FIRST HILL DENTAL CENTER
901 Boren Ave, Suite 1500
Seattle, WA 98104
info@firsthilldentalcenter.com
206-323-3830

_____

Signature (responsible party) Date

First Hill Dental Center

FINANCIAL POLICY

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have an established Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options.

1. Cash or Personal Check
2. Visa, MasterCard, American Express, Discover, Debit Cards, HSA or FSA
3. Patient Financing
    a. Including Interest Free Financing

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed by you, to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated patient portion, not covered by insurance, is due at the time of service for all services rendered. I understand that all services are due to be paid within Thirty (30) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, Twelve percent (12%) per year will be charged on accounts 60 days from the treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services that I authorize release of all financial data.

Please make your questions and concerns known to our Account Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

_____

Signature (responsible party) Date

First Hill Dental Center

CANCELATION POLICY

As a courtesy, our office will assist with appointment reminders via: texts, emails, and if needed by phone. When appointment confirmation reminders arrive please take a moment to check your calendar and ensure that the reserved date/time works for you. Please simply click on the "confirmation" portion of the email or text to let us know you are coming. We hope this is convenient for you.

Our office requests ***two business days*** notice when making schedule changes. If you are unable to keep your reserved appointment and do not give ***two business days*** notice there is a cancelation fee of $80.00.

I agree that I am responsible for my dental appointments and that I will honor First Hill Dental Center's office policy re: cancellations. I will give two business days' notice of schedule changes and understand that if I miss an appointment I will be charged a short cancelation fee of $80.00.

Please make your questions or concerns known to our Treatment Coordinator who is happy to discuss this policy and to ensure that you have an outstanding experience.

_____

Signature (responsible party) Date

FIRST HILL DENTAL CENTER

Dental History Form

Name
Nickname
Age
Referred by
How would you rate the condition of your mouth?
Please choose one of the following ❑ Excellent ❑ Good ❑ Fair ❑ Poor

PREVIOUS DENTIST

How long have you been a patient? Months/Years
Date of most recent dental exam
Date of most recent x-rays
Date of most recent treatment (other than a cleaning)
I routinely see my dentist every:
Please choose one of the following: ❑ 3 mo. ❑ 4 mo. ❑ 6 mo. ❑ 12 mo. ❑ Not routinely
What is your immediate concern?

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

PERSONAL HISTORY			
1. Are you fearful of dental treatment?	❑ Yes ❑ No		
How fearful, on a scale of 1 (least) to 10 (most)			
PERSONAL HISTORY			
2. Have you had an unfavorable dental experience?	❑ Yes ❑ No	3. Have you ever had complications from past dental treatment?	❑ Yes ❑ No
4. Have you ever had trouble getting numb or had any reactions to local anesthetic?	❑ Yes ❑ No	5. Did you ever have braces, orthodontic treatment or had your bite adjusted?	❑ Yes ❑ No
6. Have you had any teeth removed?	❑ Yes ❑ No		
GUM AND BONE			
7. Do your gums bleed or are they painful when brushing or flossing?	❑ Yes ❑ No	8. Have you ever been treated for gum disease or been told you have lost bone around your teeth?	❑ Yes ❑ No
9. Have you ever noticed an unpleasant taste or odor in your mouth?	❑ Yes ❑ No	10. Is there anyone with a history of periodontal disease in your family?	❑ Yes ❑ No
11. Have you ever experienced gum recession?	❑ Yes ❑ No	12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple?	❑ Yes ❑ No
13. Have you experienced a burning sensation in your mouth?	❑ Yes ❑ No		

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

TOOTH STRUCTURE

14. Have you had any cavities within the past 3 years?	❑ Yes ❑ No	15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food?	❑ Yes ❑ No
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth?	❑ Yes ❑ No	17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth?	❑ Yes ❑ No
18. Do you have grooves or notches on your teeth near the gum line?	❑ Yes ❑ No	19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling?	❑ Yes ❑ No
20. Do you frequently get food caught between any teeth?	❑ Yes ❑ No		

BITE AND JAW JOINT

21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping)	❑ Yes ❑ No	22. Do you feel like your lower jaw is being pushed back when you bite your teeth together?	❑ Yes ❑ No
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods?	❑ Yes ❑ No	24. Have your teeth changed in the last 5 years, become shorter, thinner or worn?	❑ Yes ❑ No
25. Are your teeth crowding or developing spaces?	❑ Yes ❑ No	26. Do you have more than one bite and squeeze to make your teeth fit together?	❑ Yes ❑ No
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits?	❑ Yes ❑ No	28. Do you clench your teeth in the daytime or make them sore?	❑ Yes ❑ No
29. Do you have any problems with sleep or wake up with an awareness of your teeth?	❑ Yes ❑ No	30. Do you wear or have you ever worn a bite appliance?	❑ Yes ❑ No

SMILE CHARACTERISTICS

31. Is there anything about the appearance of your teeth that you would like to change?	❑ Yes ❑ No	32. Have you ever whitened (bleached) your teeth?	❑ Yes ❑ No
33. Have you felt uncomfortable or self conscious about the appearance of your teeth?	❑ Yes ❑ No	34. Have you been disappointed with the appearance of previous dental work?	❑ Yes ❑ No

Patient's Signature
Date:
Doctor's Signature
Date:

FIRST HILL DENTAL CENTER

Medical History Form

Patient Name
Nickname
Age
Name of Physician/and their specialty
Most recent physical examination
Purpose
What is your estimate of your general health?
Please choose from the following: ❑ Excellent ❑ Good ❑ Fair ❑ Poor
1. HAVE YOU EVER HAD AN ALLERGIC REACTION TO: ❑ (a) aspirin, ibuprofen, acetaminophen, codeine ❑ (b) penicillin ❑ (c) erythromycin ❑ (d) tetracycline ❑ (e) sulfa ❑ (f) local anesthetic ❑ (g) fluoride ❑ (h) metals (nickel, gold, silver, other) ❑ (i) latex ❑ (j) other
DO YOU HAVE or HAVE YOU EVER HAD: ❑ 2. hospitalization for illness or injury ❑ 3. heart problems or cardiac stent within the last six months ❑ 4. history of infective endocarditis ❑ 5. artificial heart valve, repaired heart defect (PFO) ❑ 6. pacemaker or implantable defibrillator ❑ 7. artificial prosthesis (heart valve or joints) ❑ 8. rheumatic or scarlet fever ❑ 9. high or low blood pressure ❑ 10. a stroke (taking blood thinners) ❑ 11. anemia or other blood disorder ❑ 12. prolonged bleeding due to a slight cut (INR3.5) ❑ 13. emphysema, shortness of breath, sarcoidosis ❑ 14. tuberculosis, measels, chicken pox ❑ 15. asthma ❑ 16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus) ❑ 17. kidney disease ❑ 18. liver disease ❑ 19. jaundice ❑ 20. thyroid, parathyroid disease, or calcium deficiency ❑ 21. hormone deficiency ❑ 22. high cholesterol or taking statin drugs ❑ 23. diabetes (HbA1c: ____) ❑ 24. stomach or duodenal ulcer ❑ 25. digestive disorders (i.e. gastric reflux) ❑ 26. osteoporosis/osteopenia (i.e. taking bisphosphonates) ❑ 27. arthritis, rheumatoid arthritis, lupus ❑ 28. glaucoma ❑ 29. contact lenses

DO YOU HAVE or HAVE YOU EVER HAD:

- ❑ 30. head or neck injuries
- ❑ 31. epilepsy, convulsions (seizures)
- ❑ 32. neurologic disorders (ADD/ADHD, prion disease)
- ❑ 33. viral infections and cold sores
- ❑ 34. any lumps or swelling in the mouth
- ❑ 35. hives, skin rash, hay fever
- ❑ 36. STI/STD
- ❑ 37. hepatitis (type ___)
- ❑ 38. HIV / AIDS
- ❑ 39. tumor, abnormal growth
- ❑ 40. radiation therapy
- ❑ 41. chemotherapy, immunosuppressive
- ❑ 42. emotional problems
- ❑ 43. psychiatric treatment
- ❑ 44. antidepressant medication
- ❑ 45. alcohol / street drug use

ARE YOU:

- ❑ 46. presently being treated for any other illness
- ❑ 47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, diarrhea)
- ❑ 48. taking medication for weight management (i.e. fen-phen)
- ❑ 49. taking dietary supplements
- ❑ 50. often exhausted or fatigued
- ❑ 51. experiencing frequent headaches
- ❑ 52. a smoker, smoked previously or use smokeless tobacco
- ❑ 53. considered a touchy person
- ❑ 54. often unhappy or depressed
- ❑ 55. FEMALE - taking birth control pills
- ❑ 56. FEMALE - pregnant
- ❑ 57. MALE - prostate disorders

Describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

Please describe:

List all medications, supplements, and or vitamins taken within the last two years

(a) Drug	(b) Purpose

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature

Date:

Doctor's Signature

Date: