PERSONAL INFORMATION FORM

Patient's Name: ________________________________ How do you prefer to be addressed: __________________
(Last, First)

Mailing Address: ____

City: ____ State: _______ Zip: ___________________

Gender: Marital Status:

Social Security Number: _________________________________ Date of Birth: ______/______/____________

Telephone: (H) ________________________ (W) ________________________ (C) _________________________

Email Address: ______________________________ Preferred Method of Contact: _________________________

Occupation: _______________________________ Employer: ____

Employer's Address: ____

City: ____ State: _______ Zip: ___________________

If Student, name of Institution: ____

City: ____ State: _______ Zip: ___________________

How did you first hear about our office: ____

If the person responsible for payment is different from the patient or if this patient is a minor, the responsible party must fill out the section below. Otherwise, please skip to the section entitled "Primary Insurance Information"

Name of Responsible Party________________________________ Relationship to Patient: ___________________
(Last, First)

Mailing Address: ____

City: ____ State: _______ Zip: __________________

Gender: Marital Status:

Social Security Number: _________________________________ Date of Birth: ______/______/____________

Telephone: (H) ________________________ (W) ________________________ (C) ________________________

Email Address: ______________________________ Preferred Method of Contact: ________________________

Occupation: _______________________________ Employer: ____

Employer's Address: ____

City: ____ State: _______ Zip: __________________

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PRIMARY INSURANCE INFORMATION

Policy Holder's Name: ________________________________ Relationship to Patient: __________________
(Last, First)

Social Security Number: ______________________________ Date of Birth: ______/______/____________

Employer: ____

Employer's Address: ____

City: ____ State: _______ Zip: __________________

Insurance Co. _______________________________ Group/Policy #: ________________________________

Insurance Co. Address: ____

City: ____ State: _______ Zip: __________________

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: ________________________________ Relationship to Patient: __________________
(Last, First)

Social Security Number: ______________________________ Date of Birth: ______/______/____________

Employer: ____

Employer's Address: ____

City: ____ State: _______ Zip: __________________

Insurance Co. _______________________________ Group/Policy #: ________________________________

Insurance Co. Address: ____

City: ____ State: _______ Zip: __________________

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Prestige Dental to check and verify my credit and/or employment history. I further understand that Prestige Dental will assist me in filing my claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my photos for educational purposes.

If the patient is a minor, as the responsible party I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 1.5% per month. Thank you for your cooperation.

Signature of Patient (Guardian if a minor): ________________________________ Date: __________________

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DENTAL HEALTH HISTORY

Patient's Name: ___________________________

Welcome to Prestige Dental. We appreciate the confidence you place in us to provide your dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any recent changes in your health, please tell us. If you have any questions, don't hesitate to ask.

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	Yes	No
Are you apprehensive about dental treatment?		
Have you had problems with previous dental treatment?		
Do you gag easily?		
Do you wear dentures?		
Does food catch between your teeth?		
Do you have difficulty in chewing your food?		
Do you chew on only one side of your mouth?		
Do you avoid brushing any part of your mouth because of pain?		
Do your gums bleed easily?		
Do your gums bleed when you floss?		
Do your gums feel swollen or tender?		
Have you ever noticed slow-healing sores in or about your mouth?		
Are your teeth sensitive?		
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?		
Cold foods or liquids?		
Sours?		
Sweets?		
Do you take fluoride supplements?		
Are you dissatisfied with the appearance of your teeth?		
Are you a habitual gum chewer or pipe smoker?		

	Yes	No
How often do you brush? ______________________		
How often do you floss? ______________________		
Does your jaw make noise so that it bothers you or others?		
Do you clench or grind your jaws frequently?		
Do your jaws ever feel tired?		
Does your jaw get stuck so that you can't open freely?		
Does it hurt when you chew or open wide to take a bite?		
Do you have earaches or pain in front of the ears?		
Do you have any jaw symptoms or headaches upon awaking in the morning?		
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities?		
Do you find jaw pain or discomfort extremely frustrating or depressing?		
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?		
Do you have a temporomandibular (jaw) disorder (TMD)?		
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?		
Are you unable to open your mouth as far as you want?		
Are you aware of an uncomfortable bite?		
Have you had a blow to the jaw (trauma)?		

MEDICAL HEALTH HISTORY:

Do you have, or have you had, any of the following?

	Yes	No
Heart Problems ______	☐	☐
Chest pain ______	☐	☐
Shortness of breath ______	☐	☐
Blood pressure problem ______	☐	☐
Heart murmur ______	☐	☐
Heart valve problem ______	☐	☐
Taking heart medication ______	☐	☐
Rheumatic fever ______	☐	☐
Pacemaker ______	☐	☐
Artificial heart valve ______	☐	☐
Blood Problems ______	☐	☐
Easy bruising ______	☐	☐
Frequent nosebleeds ______	☐	☐
Abnormal bleeding ______	☐	☐
Blood disease (anemia) ______	☐	☐
Ever require a blood transfusion? ______	☐	☐
Allergy Problems ______	☐	☐
Hay fever ______	☐	☐
Sinus problems ______	☐	☐
Skin rashes ______	☐	☐
Taking allergy medication ______	☐	☐
Asthma ______	☐	☐
Intestinal Problems ______	☐	☐
Ulcers ______	☐	☐
Weight gain or loss ______	☐	☐
Special diet ______	☐	☐
Constipation/Diarrhea ______	☐	☐
Kidney or bladder problems ______	☐	☐
Bone or Joint Problems ______	☐	☐
Arthritis ______	☐	☐
Back or neck pain ______	☐	☐
Joint replacement ______ (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy ______	☐	☐
Stroke(s) ______	☐	☐
Frequent or severe headaches ______	☐	☐
Thyroid problems ______	☐	☐
Persistent cough or swollen glands ______	☐	☐
Premedications required by physician ______	☐	☐
Cancer/Tumor ______	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?

	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other ______		

Notes: ______

______

______ Date: ______

	Yes	No
Diabetes ______	☐	☐
Urinate more than 6 times a day ______	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes ______	☐	☐
Tuberculosis or other respiratory disease ______	☐	☐
Do you drink alcohol? ______	☐	☐
If so, how much? ______		
Do you smoke? ______	☐	☐
If so, how much? ______		
Hepatitis, jaundice, or liver trouble ______	☐	☐
Herpes or other STD ______	☐	☐
HIV-positive/AIDS ______	☐	☐
Glaucoma ______	☐	☐
Do you wear contact lenses? ______	☐	☐
History of head injury? ______	☐	☐
Epilepsy or other neurological disease? ______	☐	☐
History of alcohol or drug abuse? ______	☐	☐

Do you have any disease, condition, or problem not listed previously that you feel we should know about?
If so, please describe: ______

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐
Other ______		

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: ______		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms? ______		

Notes: ______

______

Patient/Parent Signature: ______

Dentist Initial: ______

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your our obligations and your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Your Rights as our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Prestige Dental. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Prestige Dental reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only ______	◯ YES	◯ NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses) _	◯ YES	◯ NO
Any Member of my extended family: (Parents, Grandchildren) ______	◯ YES	◯ NO
Other: ______	◯ YES	◯ NO

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____
Printed name of patient (if 18 years or older) or responsible party

____
Relationship to patient

____
Signature of patient (if 18 years or older), or responsible party

____
Responsible party contact information (phone or e-mail)

____
Date

OFFICE USE ONLY BELOW THIS LINE

	Acknowledgement Not Obtained
Provided Prior to Treatment?	YES NO Date Statement Provided: ____________________
Reason for not obtaining patient signature	Needed more time to review Statement of Privacy Practices Wanted to consult another person before signing Physically unable to sign No reason offered Other: ________________________________

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FINANCIAL POLICY

Welcome to Prestige Family and Cosmetic Dentistry, where our team of dental professionals is committed to making your every visit relaxing and productive. Please sign this document to acknowledge your understanding of our Financial Policy.

Dental Insurance

You have a contract with your dental insurance company; we are not a party to that contract. While we do our best to obtain accurate information from your insurance company on your behalf, it is ultimately your responsibility to understand your policy and its limitations. Regardless of whether we are in network for your insurance, the final responsibility for all charges associated with your treatment lies with you – the patient.

Estimates

We solicit an estimate from your dental insurance company which you should consider a guideline until final insurance payment is received and your account has been reconciled. We make every effort to provide accurate estimates, but our office can make no guarantee that insurance payments will match our estimates.

Claims

We promptly submit a claim to your insurance company after treatment. Any claim that is unpaid is billed directly to you.

Predeterminations

At your request, we will gladly process your predetermination, but please be aware that predeterminations are not guarantees of payment.

Payment Is Due At the Time of Service

You may have an out-of-pocket portion (coinsurance) which is determined by information and percentages provided by your insurance company. Your coinsurance portion will be presented in an estimate prior to scheduling your appointment. A deposit or prepayment is required to hold an appointment and is calculated based on the treatment scheduled, duration of appointment, time and day of the week.

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Appointment Cancellations

We understand that sometimes you will need to reschedule your treatment. We respectfully request that you provide us with 48 hours advance notice. If your appointment is on a Saturday or Monday, we request 72 hours advance notice, as Saturday appointments are in very high demand. Without this advance notice, you will be charged $50.00 per half hour of missed appointment time.

Service Charges

Accounts which are 60 days past due are assessed a monthly finance charge equivalent to an annual rate of 10.0%. Outstanding balances and applicable fees will be forwarded to a collection agency after 120 days of no response.

Services Not Covered

You, or the party responsible for your account, agree to provide payment in full for procedures performed in this office, including any treatment not covered by your dental insurance.

We accept Visa, MasterCard, and cash as form of payment.
A processing fee of 2.5% will be added to all credit transactions.

I have read, understood, and agree to this Financial Policy.

____
Printed name of patient or responsible party

____
Relationship to patient

____
Signature of patient, parent or guardian

____
Date

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