

Dr. Noreen Goldwire, DDS

Family and Cosmetic Dentistry

Canyon Park Office Center

22232 17th Ave SE, Suite 208

Bothell, WA 98021

www.goldwiredental.com

Date _____

Name of Patient _____
First Middle Last Nickname

Male Female Other

Married Single Child

Birth Date _____ Social Security # _____

Home Address _____
Street City State Zip

Email Address _____

All statements are sent out via email. If this does not work for you, please let us know.

Home Phone _____ Work Phone _____ Cell Phone _____

Please complete this section if you would like us to submit to your dental insurance:

Subscriber's Name _____ Subscriber's Birth Date _____

Relationship: Self Spouse Child Other _____

Insurance Company _____ Insurance ID# _____

Employer: _____ Group # _____ Insurance Co. Phone # _____

Secondary Insurance Plan: No Yes Insurance Co. Name _____

Emergency Contact: _____
Name Phone Relationship

Who may we thank for referring you to our office? _____

- Office Policy -

It is our goal to provide thorough, quality care for our patients. To reduce the cost of billing the following policies have been adopted.

↓Initial

____ 1. No insurance: Payment for all services provided is expected at time of service.

____ 2. Insurance coverage: Your estimated portion is expected at the time of service. Dental

insurance is a personal contract between you and your insurance company. Our office will verify your coverage limitations and eligibility. This is not a guarantee of benefits. Should your insurance deny/reject your claim, or you exceed your maximum benefits, you are ultimately responsible for all charges accrued on your behalf.

____ 3. Broken/missed appointments: We require 48 business hours' notice to change or cancel an appointment. Appointments changed with less than 48 hours' notice or missed appointments will be subject to a \$100.00 per hour charge.

I have read, understand, and agree to the Office Policy of Dr. Noreen Goldwire's office. I authorize payment of insurance benefits to this office.

Signature of Responsible Party _____ ***Date*** _____

Date: _____

Name of Patient: _____ Birth Date: _____

Former Dentist: _____

Name

City/State

Phone Number

Date of Last Dental Exam: _____ Were any x-rays taken within the last year? Yes No

Dental History

1. Do you currently have any dental problems or concerns? Yes No
 If yes: Where? _____ For How Long? _____
 Describe Symptoms _____
2. Are your teeth sensitive? Yes No
3. Do you experience sensitivity with cleanings? Yes No
4. Can you chew comfortably? Yes No
5. Are you happy with the appearance of your teeth? Yes No
6. Have you ever had problems with local anesthesia (Novocain)? Yes No
7. Have you ever had problems with dental treatment in the past? Yes No
8. Is there anything special we can do to make your dental experience more comfortable? Yes No

Headache History

- Do you have headaches? Yes No
- If yes, where is the pain located? _____
- How often do you get headaches? _____
- Please indicate your typical level of pain (low) 1 2 3 4 5 6 7 8 9 10 (high)
- Have the headaches been diagnosed? Sinus Muscular Vascular Migraine Stress
- If not diagnosed, what do you think is the cause? _____
- Have you used any medication/treatments? _____

TMJ

1. Pain in the joint itself? Yes No / Right Left Both
2. Clicking / Popping? Yes No / Right Left Both
3. Grating sound? Yes No / Right Left Both
4. How long have the symptoms been present? _____
5. Are your symptoms intermittent or constant? _____
6. Have your symptoms gotten better or worse? _____
7. Does anything make them worse? _____
8. Have you ever had a limitation of opening or closing your mouth? Yes No
9. Have you had TMJ symptoms evaluated in the past? Yes No

Patient Name: _____ Birth date: _____

Physician: _____ Location/Phone: _____

Are you currently experiencing any flu or cold like symptoms, not related to allergies? _____

Do you wish to use nitrous oxide for your treatment? (Typically, not covered by insurance) Yes No

Emergency Contact Name & Number: _____

Have you ever had any of the following diseases or medical problems? CHECK ALL THAT APPLY

A – V Shunt / CSF Shunt	High / Low Blood Pressure
Allergies	HIV / AIDS
Alzheimer's / Dementia	Implants, any type
Anemia	Kidney Disease
Arrhythmia / Pacemaker	Organ Transplant / Asplenia (no spleen)
Artificial Joints	Osteoporosis
Asthma	Prolonged Bleeding / Blood Thinners
Autoimmune Disorders / Lupus	Prosthetic Heart Valves / Stents
Cancer / Chemotherapy / Radiation	Psychiatric Problems / Depression
Canker Sores	Recent Surgery
Central IV Catheter (Hickman)	Rheumatic Fever / Scarlet Fever
Cold Sores	Severe or Frequent Headaches / Migraines
Diabetes Type1 Type2 Last A1C:	Sinus Problems
Drug / Alcohol Abuse	Stomach Ulcers / Irritable Bowel
Emphysema / Respiratory Problems	Stroke / TIA
Epilepsy / Seizure / Fainting Spells	Thyroid Disorder
Heart Attack / Angina	Tobacco Use (if Yes, what type _____)
Heart Murmur / Mitral Valve	Tuberculosis
Hepatitis: A, B, C	Other _____

Patient Name:

Are you allergic to any of the following? CHECK ALL THAT APPLY

Asprin	Erythromycin	Sulfa
Codeine	Latex	Sedatives
Dental Anesthetics	Penicillin	Tetracycline
Please list any other drug or supplement allergies: _____		

List any medications, vitamins, herbs, and/or over-the-counter medications:

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? Yes No
Yes, but I no longer need it

♀ **For Women:** Are you: Pregnant? Yes No
Nursing? Yes No
Taking oral contraceptives? Yes No

To the best of my knowledge the information I have given today is correct:

Sign _____ Date _____
 Sign _____ Date _____
 Sign _____ Date _____
 Sign _____ Date _____

For Office Use Only:	
Date	Initial
_____	_____
_____	_____
_____	_____
_____	_____

Dr. Noreen Goldwire, DDS

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**Acknowledgement of Receipt of
Statement of Privacy Practices**

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Noreen Goldwire, DDS. 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.

Noreen Goldwire, DDS 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		
<i>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.)</i>		
Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other: _____	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Patient Signature: _____ Date: _____

Patient Name (PRINT): _____

<i>If you are a parent of a minor, guardian, or personal representative fill out the following.</i>	
Patient's personal representative: (Please Print): _____	
Personal Representative's signature: _____	
Representative's Telephone Number: _____	Date: _____

Our office is dedicated to protecting 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 our obligations and your rights.

- Protecting your 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 Healthcare 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 Healthcare 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.

An expanded, and complete copy of our Statement of Privacy Practices is available for your review.