ANGELICA SUMMER, DPD **A DENTAL & DENTURE** **JON TARLETON, DDS MSD**

Patient Information Date:_____

Name: Last _____First_____M_____Preferred Name:_____

Date of Birth: _____ Family Status: ☐ Minor ☐ Single ☐ Married Gender: ☐ Male ☐ Female

Address:_____City:_____State:_____Zip:_____

Cell Phone:_____ Home Phone:_____

Email Address:_____ SSN# (for billing purpose):_____

Employer Name:_____ Work Phone: _____

I prefer to be contacted by: (check all that applies.) ☐ Cell Phone ☐ Email ☐ Home Phone ☐ Work Phone

Emergency Contact:_____ Phone:_____ Rel. to Patient:_____

Responsible Party:_____ Relationship:_____ Phone if different:_____

Insurance Information **(Skip this step if you have NO insurance)**

Name of Insured: _____Relationship to Patient:_____

ID#/SSN#:_____ Date of Birth:_____

Insurance Company:_____ Insurance Tel. No.: _____

Do you have any additional insurance? ☐ Yes ☐ No If Yes, Complete the following

Name of Insured: _____Relationship to Patient:_____

ID#/SSN#:_____ Date of Birth:_____

Insurance Company:_____ Insurance Tel. No.: _____

Insurance Authorization **(Skip this step if you have NO insurance)**

I authorize my insurance company to pay A Dental & Denture all insurance benefits rendered.
I authorize A Dental & Denture to make use of my signature on file on all insurance submissions.
I authorize A Dental & Denture to submit pre-authorization on my treatment plan.
I authorize A Dental & Denture to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Patient Signature: _____

Referred By:

☐ Friend/Family ☐ Internet_____ ☐ Insurance ☐ Social Media _____ ☐ Other _____

Financial Policy

If I do not pay the entire new balance within 60 days of monthly billing date, a service charge will be added to the account for the current monthly billing period. The service charge will be a periodic rate of 1.5% per month (or a minimum charge of $5 for a balance under $100) which is an annual percentage rate of 18% applied to the last month's balance. In the case of default of payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Patient or Responsible Party Signature_____

A DENTAL & DENTURE ASSOCIATES

Medical Doctor's Name _____ Address/Clinic Name _____ Phone _____

Date of Last Physical Examination: _____ Results _____ Pharmacy _____

Are you being treated by a medical doctor now? ☐ Yes ☐ No If yes, for what reason?

_____

Are you sensitive or have allergies to any medicine? ☐ Yes ☐ No If yes, what?

(Local Anesthetic) (Aspirin) (Penicillin) (Codeine) (Sulfa) (Iodine) (Latex) Other: _____

Have you ever been hospitalized or had any surgical operations? ☐ Yes ☒ No If yes, list reasons and dates

_____

List any medications you are currently taking:

_____

Have you had:

☐ Yes ☐ No AIDS / HIV Positive
☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Allergies:_____
☐ Yes ☐ No Anemia
☐ Yes ☐ No Arthritis
☐ Yes ☐ No Artificial Heart Valves
☐ Yes ☐ No Artificial Joints
☐ Yes ☐ No Asthma
☐ Yes ☐ No Back Problems
☐ Yes ☐ No Blood disease
☐ Yes ☐ No Cancer _____
☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Circulation problems
☐ Yes ☐ No Cortisone treatments
☐ Yes ☐ No Cough, persistent
☐ Yes ☐ No Cough, up blood
☐ Yes ☐ No Diabetes
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fainting
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Headaches, frequent
☐ Yes ☐ No Headaches, migraines
☐ Yes ☐ No Heart murmur
☐ Yes ☐ No Heart, any problems_____
☐ Yes ☐ No Hemophilia
☐ Yes ☐ No Herpes
☐ Yes ☐ No Hepatitis A B C
☐ Yes ☐ No High Blood Pressure
☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Mitral Valve Prolapse
☐ Yes ☐ No Nervous Problems
☐ Yes ☐ No Pacemaker
☐ Yes ☐ No Psychiatric care
☐ Yes ☐ No Radiation Treatment
☐ Yes ☐ No Respiratory disease
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Seizures Disorders
☐ Yes ☐ No Shingles
☐ Yes ☐ No Shortness of Breath
☐ Yes ☐ No Skin Rash
☐ Yes ☐ No Stroke
☐ Yes ☐ No Surgical Implants
☐ Yes ☐ No Swelling feet
☐ Yes ☐ No Thyroid problem
☐ Yes ☐ No Tobacco Use
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Ulcer Colitis

☐ Yes ☐ No Do you bruise easily?
☐ Yes ☐ No Excessive bleeding from a cut or wound?
☐ Yes ☐ No Does your mouth frequently become dry?
☐ Yes ☐ No Do you have difficulty swallowing?

Do you have any disease, condition or problem not listed?

If yes, explain:

_____

Females: ☐ Yes ☐ No Are you pregnant? (Due Date _____)
☐ Yes ☐ No Are you taking oral contraceptives (Birth Control Pills)?

Patient Name: _____ Date Today: _____ /_____ /20_____

PATIENT MEDICAL INFORMATION AND HISTORY

Check if you have had any problems with the following:

☐ Yes ☐ No Do you have any teeth that are hurting?
☐ Yes ☐ No Have you had any serious trouble associated with any previous dental treatment?

If yes, explain:

_____

_____

☐ Yes ☐ No Do you clench or grind your teeth?
☐ Yes ☐ No Have you ever received treatment for periodontal disease?
☐ Yes ☐ No Do you like the way your teeth look?
☐ Yes ☐ No Bad Breath
☐ Yes ☐ No Clicking or popping jaw when you chew: Left or Right
☐ Yes ☐ No Food trapped between teeth
☐ Yes ☐ No Loose Teeth
☐ Yes ☐ No Periodontal treatment
☐ Yes ☐ No Sensitivity to (cold) (hot) (sweets) (biting)
☐ Yes ☐ No Sores in mouth

Denture patients only:

Age of Denture/Partial: Upper _____ Lower _____
☐ Yes ☐ No Do you use adhesive on your dentures? Upper / Lower / Both
☐ Yes ☐ No Did you ever had your denture/partial relined? When? Upper:_____ Lower: _____
☐ Yes ☐ No Did you ever had your denture/partial repair?
What product or material do you use to clean your denture? _____

Authorization:

I have reviewed the information and answered all questions of my medical and dental history to the best of my knowledge. I understand this information will be used to determine the dental treatment I receive at this office and may be shared with other medical offices only as necessary. I will notify the office should any information change in the future.

Patient Name: _____

Signature of patient or parent if a minor: _____

Reviewed by: _____

PATIENT DENTAL HISTORY

A DENTAL & DENTURE ASSOCIATES - HIPAA

- I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of A Dental & Denture Associates, LLC.
- 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.
- A Dental & Denture Associates, LLC 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.)

☐ YES ☐ NO - 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 _____

Date: _____

Name of Patient (please print):_____

Patient Signature (if 18 years old or older):_____

Patient's Personal Representative: (Please Print):_____

Personal Representative's Signature: _____

Representative's Telephone Number: _____

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

☐ YES ☐ NO Provided Prior to Treatment?

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:

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES -HIPAA

A DENTAL & DENTURE ASSOCIATES

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.

A Dental & Denture Associates, LLC
11540 15th Ave NE * Seattle, Washington 98125 - 206-440-1500

STATEMENT OF PRIVACY PRACTICES