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Welcome

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

Patient Information

Name _____ Soc. Sec. # _____
Last Name First Name Middle Initial

Address _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Sex M F Age _____ Birthdate _____ Single Married Widowed Separated Divorced

Patient Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Whom may we thank for referring you? _____

Notify in case of emergency _____ Home Phone _____ Business Phone _____

Cell Phone _____ Email _____

Primary Insurance

Person Responsible for Account _____
Last Name First Name Middle Initial

Relation to Patient _____ Birthdate _____ Soc. Sec. # _____

Address (if different from patient) _____ Home Phone _____

City _____ State _____ Zip _____

Cell Phone _____ Email _____

Person Responsible Employed by _____ Occupation _____

Business Address _____

Business Email _____ Business Phone _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Additional Insurance

Is patient covered by additional insurance? Yes No

Subscriber's Name _____ Relation to Patient _____ Birthdate _____

Address (if different from patient) _____ Soc. Sec. # _____

City _____ State _____ Zip _____ Home Phone _____

Cell Phone _____ Email _____

Subscriber Employed by _____ Business Phone _____

Business Email _____

Insurance Company _____ Phone _____

Insurance Email _____

Contract # _____ Group # _____ Subscriber's # _____

Name(s) of other dependents under this plan _____

Please complete both sides

Dental History

What would you like us to do today? _____

Are you in dental discomfort today? _____

Former Dentist _____ Address _____ Phone _____

Dentist's Email _____

Date of last dental care _____ Date of last X-rays _____

Check Y for yes or N for no if you have or have not had the following:

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N Bad breath | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to sweets | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to cold | <input type="checkbox"/> Y <input type="checkbox"/> N Loose teeth or broken fillings |
| <input type="checkbox"/> Y <input type="checkbox"/> N Food collection between teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding gums | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity when biting | <input type="checkbox"/> Y <input type="checkbox"/> N Sensitivity to hot |
| <input type="checkbox"/> Y <input type="checkbox"/> N Periodontal treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Grinding or clenching teeth | <input type="checkbox"/> Y <input type="checkbox"/> N Clicking or popping jaw | <input type="checkbox"/> Y <input type="checkbox"/> N Sores or growths in mouth |

How often do you brush? _____ How often do you floss? _____

How do you feel about the appearance of your teeth? _____

Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? Y N

Medical History

Physician's name _____ Address _____ Phone _____

Physician's Email _____

Date of last visit _____ Have you had any serious illnesses or operations? Y N If yes, describe _____

Are you currently under physician care? Y N If yes, describe _____

Have you ever had a blood transfusion? Y N If yes, give approximate date(s) _____

Have you ever taken Fen-Phen/Redux? Y N

Women: Are you pregnant? Y N Nursing? Y N Taking birth control pills? Y N

Check Y for yes or N for no if you have or have not had the following:

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Y <input type="checkbox"/> N AIDS/HIV Positive | <input type="checkbox"/> Y <input type="checkbox"/> N Cough, persistent | <input type="checkbox"/> Y <input type="checkbox"/> N High blood pressure | <input type="checkbox"/> Y <input type="checkbox"/> N Shingles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anaphylaxis | <input type="checkbox"/> Y <input type="checkbox"/> N Cough up blood | <input type="checkbox"/> Y <input type="checkbox"/> N Jaw pain | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of breath |
| <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Diabetes | <input type="checkbox"/> Y <input type="checkbox"/> N Kidney disease or malfunction | <input type="checkbox"/> Y <input type="checkbox"/> N Skin rash |
| <input type="checkbox"/> Y <input type="checkbox"/> N Arthritis, Rheumatism | <input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy | <input type="checkbox"/> Y <input type="checkbox"/> N Liver disease | <input type="checkbox"/> Y <input type="checkbox"/> N Spina Bifida |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial heart valves | <input type="checkbox"/> Y <input type="checkbox"/> N Fainting | <input type="checkbox"/> Y <input type="checkbox"/> N Material allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Stroke |
| <input type="checkbox"/> Y <input type="checkbox"/> N Artificial joints | <input type="checkbox"/> Y <input type="checkbox"/> N Food allergies | <input type="checkbox"/> Y <input type="checkbox"/> N (latex, wool, metal, chemicals) | <input type="checkbox"/> Y <input type="checkbox"/> N Surgical implant |
| <input type="checkbox"/> Y <input type="checkbox"/> N Asthma | <input type="checkbox"/> Y <input type="checkbox"/> N Glaucoma | <input type="checkbox"/> Y <input type="checkbox"/> N Mitral valve prolapse | <input type="checkbox"/> Y <input type="checkbox"/> N Swelling of feet or ankles |
| <input type="checkbox"/> Y <input type="checkbox"/> N Atopic (allergy prone) | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Nervous problems | <input type="checkbox"/> Y <input type="checkbox"/> N Thyroid disease or |
| <input type="checkbox"/> Y <input type="checkbox"/> N Back problems | <input type="checkbox"/> Y <input type="checkbox"/> N Heart murmur | <input type="checkbox"/> Y <input type="checkbox"/> N Pacemaker/Heart surgery | <input type="checkbox"/> Y <input type="checkbox"/> N malfunction |
| <input type="checkbox"/> Y <input type="checkbox"/> N Blood disease | <input type="checkbox"/> Y <input type="checkbox"/> N Heart problems | <input type="checkbox"/> Y <input type="checkbox"/> N Psychiatric care | <input type="checkbox"/> Y <input type="checkbox"/> N Tobacco habit |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cancer | Describe _____ | <input type="checkbox"/> Y <input type="checkbox"/> N Rapid weight gain or loss | <input type="checkbox"/> Y <input type="checkbox"/> N Tonsillitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemical dependency | <input type="checkbox"/> Y <input type="checkbox"/> N Hemophilia/
Abnormal bleeding | <input type="checkbox"/> Y <input type="checkbox"/> N Radiation treatment | <input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Chemotherapy | <input type="checkbox"/> Y <input type="checkbox"/> N Herpes | <input type="checkbox"/> Y <input type="checkbox"/> N Respiratory disease | <input type="checkbox"/> Y <input type="checkbox"/> N Ulcer/Colitis |
| <input type="checkbox"/> Y <input type="checkbox"/> N Circulatory problems | <input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis | <input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic fever | <input type="checkbox"/> Y <input type="checkbox"/> N Venereal disease |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cortisone treatments | | <input type="checkbox"/> Y <input type="checkbox"/> N Scarlet fever | |

List medications you are currently taking, if any:

List drug allergies, if any:

Authorization

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist.

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist 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.

Signature _____ Date _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

MAY CREEK FAMILY DENTISTRY

Steven R. Lee, D.D.S.
1620 Duvall Ave NE #A
Renton, WA 98059
425-271-6002

FINANCIAL POLICY:

Thank you for choosing our office to provide you with your dental care. The following is a statement of our Financial Policy, which we require our patients to sign after reading. After an examination and diagnosis we will provide you with an estimate of the recommended treatment for you.

TYPES OF PAYMENTS ACCEPTED: We accept cash, check, MasterCard, Visa and Discover

DENTAL INSURANCE: As a courtesy we will gladly file your insurance claims and accept assignment of dental benefits. Most insurance companies will not cover 100% of all dental treatments. We will do our best to estimate your portion of the treatment. Please be aware that we are only able to approximate your portion due to the large number of insurance companies and the periodic changes within their contracts. The portion not covered by insurance is due at the time the treatment is performed unless otherwise agreed on. To be able to file your claims, you must provide us with your insurance card and all pertinent information required filing your claims. Remember that your insurance policy is a contract between you, your employer and the insurance company. You are only responsible for our fees and not what the insurance company allows. We do not file claims for your medical insurance. Patients without insurance coverage are responsible for their fee the day of treatment.

MISSED APPOINTMENTS: Broken or missed appointments prevent other patients from receiving the dental care that they deserve. We take them seriously so please be considerate and give our office at least 48 hours' notice if you need to change an appointment. Appointments missed or broken without the 48 hours' notice may be charged a fee up to **\$100.00.**

RETURNED CHECKS: There will be a fee of \$30.00 charged to your account for checks returned from the bank.

MINOR PATIENTS: The parent or guardian accompanying the minor is responsible for the full payment. In the case of a divorce or separation, the parent who brings the child to the office is the responsible party. We will not attempt to collect payment from a parent that is not present with the child in the office. The patient or guardian agrees to be fully responsible for the total payment for all treatments performed in this office.

I certify I have read, understood, and agreed to this Financial Policy and Agreement.

Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

May Creek Family Dentistry - Renton, WA

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my healthcare provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my healthcare provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)

OTHER-SPECIFY	Names	Signatures	ID	ETC.
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----- **For Office Use Only:**

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- _____ The patient refused to sign
- _____ Communication barriers
- _____ Emergency situation
- _____ Other