

PATIENT INFORMATION

First Name: Last Name: Date of birth: M F

Home address: City: St: Zip:

Billing address (if different): City: St: Zip:

Home Phone: Cell phone: Work phone:

Email: Employer:

Primary insurance: Subscriber's name: DOB:

Group number: ID / SS#:

Secondary insurance: Subscriber's name: DOB:

Group number: ID / SS#:

DENTAL HEALTH HISTORY

	Yes	No		Yes	No
Are you apprehensive about dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	How often do you brush? <input type="text"/>		
Have you had problems with previous dental treatment? _____	<input type="checkbox"/>	<input type="checkbox"/>	How often do you floss? <input type="text"/>		
Do you gag easily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw make noise so that it bothers you or others? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear dentures? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you clench or grind your jaws frequently? _____	<input type="checkbox"/>	<input type="checkbox"/>
Does food catch between your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do your jaws ever feel tired? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have difficulty chewing your food? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your jaw get stuck so that you can't open freely? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you chew on only one side of your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does it hurt when you chew or open wide to take a bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you avoid brushing any part of your mouth because of pain? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have earaches or pain in front of the ears? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed easily? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any jaw symptoms or headaches upon awaking in the morning? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums bleed when you floss? _____	<input type="checkbox"/>	<input type="checkbox"/>	Does jaw pain or discomfort affect your appetite sleep, daily routine, or other activities? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do your gums feel swollen or tender? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you find jaw pain or discomfort extremely frustrating or depressing? _____	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever noticed slow-healing sores in or about your mouth? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are your teeth sensitive? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have a temporomandibular (jaw) disorder (TMD)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you feel twinges of pain when your teeth come in contact with:			Are you a habitual gum chewer or pipe smoker? _____	<input type="checkbox"/>	<input type="checkbox"/>
Hot foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Cold foods or liquids? _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you have pain in the face, cheeks, jaws, joints, throat, or temples? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sweets? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you unable to open your mouth as far as you want? _____	<input type="checkbox"/>	<input type="checkbox"/>
Sours? _____	<input type="checkbox"/>	<input type="checkbox"/>	Are you aware of an uncomfortable bite? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you take fluoride supplements? _____	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a blow to the jaw (trauma)? _____	<input type="checkbox"/>	<input type="checkbox"/>
Are you dissatisfied with the appearance of your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>			
Do you prefer to save your teeth? _____	<input type="checkbox"/>	<input type="checkbox"/>			
Do you want complete dental care? _____	<input type="checkbox"/>	<input type="checkbox"/>			

MEDICAL HEALTH HISTORY

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

	Yes	No
Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood pressure problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur _____	<input type="checkbox"/>	<input type="checkbox"/>
Heart valve problem _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking heart medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker _____	<input type="checkbox"/>	<input type="checkbox"/>
Artificial heart valve _____	<input type="checkbox"/>	<input type="checkbox"/>

Blood Problems	<input type="checkbox"/>	<input type="checkbox"/>
Easy bruising _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent nosebleed _____	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal bleeding _____	<input type="checkbox"/>	<input type="checkbox"/>
Blood disease (anemia) _____	<input type="checkbox"/>	<input type="checkbox"/>
Ever require a blood transfusion? _____	<input type="checkbox"/>	<input type="checkbox"/>

Allergy Problems	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever _____	<input type="checkbox"/>	<input type="checkbox"/>
Sinus problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Taking allergy medication _____	<input type="checkbox"/>	<input type="checkbox"/>
Asthma _____	<input type="checkbox"/>	<input type="checkbox"/>

Intestinal Problems	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers _____	<input type="checkbox"/>	<input type="checkbox"/>
Weight gain or loss _____	<input type="checkbox"/>	<input type="checkbox"/>
Special diet _____	<input type="checkbox"/>	<input type="checkbox"/>
Constipation/Diarrhea _____	<input type="checkbox"/>	<input type="checkbox"/>
Kidney or bladder problems _____	<input type="checkbox"/>	<input type="checkbox"/>

Bone or Joint Problems	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis _____	<input type="checkbox"/>	<input type="checkbox"/>
Back or neck pain _____	<input type="checkbox"/>	<input type="checkbox"/>
Joint replacement (e.g., total hip, pins, or implants) _____	<input type="checkbox"/>	<input type="checkbox"/>
Fainting Spells, Seizures, or Epilepsy _____	<input type="checkbox"/>	<input type="checkbox"/>
Stroke(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
Frequent or severe headaches _____	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid problems _____	<input type="checkbox"/>	<input type="checkbox"/>
Persistent cough or swollen glands _____	<input type="checkbox"/>	<input type="checkbox"/>

Premedications required by physician	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumor _____	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics ("Novocaine")	<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives, or sleeping pills	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin, Acetaminophen, or Ibuprofen	<input type="checkbox"/>	<input type="checkbox"/>
Codeine, Demerol, or other narcotics	<input type="checkbox"/>	<input type="checkbox"/>
Reaction to metals	<input type="checkbox"/>	<input type="checkbox"/>
Latex or rubber dam	<input type="checkbox"/>	<input type="checkbox"/>

Other _____

Notes _____

Signature _____

	Yes	No
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Urinate more than 6 times a day _____	<input type="checkbox"/>	<input type="checkbox"/>
Thirsty or mouth is dry much of the time _____	<input type="checkbox"/>	<input type="checkbox"/>
Family history of diabetes _____	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis or other respiratory disease _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you drink alcohol? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Do you smoke? _____	<input type="checkbox"/>	<input type="checkbox"/>
If so, how much? _____		
Hepatitis, jaundice, or liver trouble _____	<input type="checkbox"/>	<input type="checkbox"/>
Herpes or other STD _____	<input type="checkbox"/>	<input type="checkbox"/>
HIV-positive / AIDS _____	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear contact lenses? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of head injury? _____	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy or other neurological disease? _____	<input type="checkbox"/>	<input type="checkbox"/>
History of alcohol or drug abuse? _____	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____	<input type="checkbox"/>	<input type="checkbox"/>

During the past 12 months, have you taken any of the following?	Yes	No
Antibiotics or sulfa drugs	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants (e.g., Coumadin)	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure medicine	<input type="checkbox"/>	<input type="checkbox"/>
Tranquilizers	<input type="checkbox"/>	<input type="checkbox"/>
Insulin, Orinase, or similar drug	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
Digitalis or drugs for heart trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nitroglycerin	<input type="checkbox"/>	<input type="checkbox"/>
Cortisone (steroids)	<input type="checkbox"/>	<input type="checkbox"/>
Natural remedies	<input type="checkbox"/>	<input type="checkbox"/>
Nonprescription drug/supplements	<input type="checkbox"/>	<input type="checkbox"/>
Other _____		

Women	Yes	No
Are you taking contraceptives or other hormones?	<input type="checkbox"/>	<input type="checkbox"/>
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
If so, expected delivery date:		
Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
Have you reached menopause?	<input type="checkbox"/>	<input type="checkbox"/>
If so, do you have any symptoms?		

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

Date _____

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to providing you with the best and most appropriate dental care to suit your individual needs. To facilitate quality care, we believe it is important that you be kept well informed. Good communication is essential to a healthy provider-patient relationship.

The following financial policy will assist you in handling your account with us.

Please read this form carefully, initial and sign below. We are happy to answer any questions, please do not hesitate to ask.

INSURANCE	
We file insurance claims as a courtesy to our patients. All charges are your responsibility from the date services are rendered. Our office cannot guarantee the insurance payment as estimated.	Initials <input style="width: 50px; height: 20px;" type="text"/>
Acceptance of Insurance: As dental care providers we must emphasize that our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract except where we are preferred provider. Your plan benefits depend solely on what your employer wishes to offer you and your fellow employees. The extent of coverage has nothing to do with the level of service provided by our office and the fee charged for these services.	Initials <input style="width: 50px; height: 20px;" type="text"/>
For your convenience, we will call your insurance company to verify patient eligibility as well as obtain an estimate of insurance coverage. However, insurance plans vary greatly in the types of coverage they offer and we expect you to become familiar with your policy's benefits and limitations. Furthermore, as your insurance company will inform you when you call, "benefits quoted are not a guarantee of payment as they are subject to current plan provisions or eligibility." You will be held financially responsible for services, which are not covered by your insurance plan.	Initials <input style="width: 50px; height: 20px;" type="text"/>
Based on information provided by your insurance company, we will provide an estimate that will show expected insurance payment and estimated patient payment for each procedure. However, the estimated insurance payment should be considered a guideline until the final insurance payment is received and posted to your account. Please note that our fees may not correspond with those of your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates (UCR) and alternate benefit provisions. If you have questions regarding UCR, please ask.	Initials <input style="width: 50px; height: 20px;" type="text"/>
FEES & PAYMENTS	
We share your concerns about the cost of dental care. Our fees have been thoughtfully worked out to reflect fair charges for our time, expertise, materials and the complexity of your treatment. We expect payment in full at the time of service. We accept cash, checks and major credit cards. Returned Checks: There will be a \$25.00 handling charge for any returned checks. Financing: For the convenience of our patients, we offer CareCredit through an outside financing company. Please ask to speak with our Patient Care Coordinator to learn more about financing treatment through CareCredit.	Initials <input style="width: 50px; height: 20px;" type="text"/>
The treatment fee is based on information gained from an examination of the patient and review of patient information. Should additional problems arise as treatment progresses, this estimated fee is subject to change. The patient will be informed of any increased fees and/or additional recommended treatment. Any treatment cost not covered by insurance will be due at the time of treatment.	Initials <input style="width: 50px; height: 20px;" type="text"/>
Finance Charge: The total balance of account is subject to a 1.5% per month (18% APR) service charge after 60 days. If any installments are not paid when due, the whole, unpaid balance may, at our option, become immediately due.	Initials <input style="width: 50px; height: 20px;" type="text"/>

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party	Date
Printed Name	Responsible Party's Relationship to Patient

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

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.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires that all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose our health information.

Without specific written authorization, we are permitted to use and disclose your protected health information (PHI) for the purposes of providing your treatment, obtaining payment and conducting health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care within our office. In addition, we may share your health information with specialists, physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.
- **Payment** means such activities as obtaining insurance reimbursement for services rendered, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information on an invoice used to collect payment for treatment you receive in our office, when billing your dental insurance for your dental services or determining the coverage allowed by your benefits plan.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for business planning and development that involves conducting cost-management and plan-related analysis related to managing and operating the entity, including formulary development and administration, necessary to facilitate needed care.

Unless you request otherwise, we may use or disclose your PHI to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care.

In addition, we may disclose your health information to insurance companies or government appointed agencies as part of their quality assurance and compliance care.

In addition, because we believe regular care is very important to your oral and general health, we may use your confidential information to remind you of scheduled appointments or that it is time for you to contact us and make an appointment by sending you reminder postcards, letters and/or leaving messages or voicemail at home and/or work. We may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

In addition, we may disclose your health information for public oversight activities, for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or report suspected abuse, neglect, or domestic violence.

Any other use and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain used and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee will be assessed for duplication and assembly of your copy.
- The right to request an amendment to your protected health information. We may however, deny your request if the health information in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.
- The right to receive and accounting of disclosures of protected health information make for any reason other than for treatment, payment, or health care operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice went into effect on April 14, 2003, and will remain in effect until we replace it. We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. To do so, please request a complaint form from our privacy director. We will not retaliate against you filing a complaint.

For more information about our Privacy Practices, please contact: Hamamoto Dentistry
22703 Bothell Everett HWY Suite E
Bothell, WA 98021
(425) 488-1480

For more information about HIPAA or to file a complaint: US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
(877) 696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 (HIPPA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up 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 dental 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 dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the above address to obtain a current copy of the *Notice of Privacy Practices*.

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. I also 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.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

- | | | | | |
|---|--------------------------|-----|--------------------------|----|
| ANY member of my IMMEDIATE family | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| My SPOUSE only | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |
| OTHER, please specify: <input style="width: 150px;" type="text"/> | <input type="checkbox"/> | YES | <input type="checkbox"/> | NO |

Signature of Patient or Responsible Party	Date
Printed Name	Responsible Party's Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Initials: Date:

CANCELLATION POLICY

Restorative and Hygiene Appointments

We are committed to providing you with the best and most appropriate dental care to suit your individual needs. The treatment that is planned for you is specific to you, and *it is important for you to keep the scheduled dates and times to properly complete your treatment.*

We ask for *at least 48 hours advance notice (2 business days)* for cancelling or rescheduling an appointment. A broken appointment is a loss to three people – the patient who missed the valuable time, the patient who could have taken the valuable time, and the doctor who was fully staffed and prepared for the appointment.

425-488-1480 ← Please take a moment to save our number.

All no-show or canceled appointments will be subject to a fee of \$75.00 per scheduled hour.

This fee will be added to your account. Please note that *all cancellation fees must be paid prior to scheduling another appointment.*

Frequent cancellations and/or significant tardiness, short notices changes, and repeatedly missed appointments may result in dismissal.

Thank you for your consideration and we look forward to working with you!

I have read the Cancellation Policy. I understand and agree to this Cancellation Policy:

<input type="text"/>	<input type="text"/>
Signature of Patient or Responsible Party	Date
<input type="text"/>	<input type="text"/>
Printed Name	Responsible Party's Relationship to Patient