DENTAL CARE OF VASHON
ADVANCED FAMILY & COSMETIC DENTISTRY

NEW PATIENT REGISTRATION

Patient: _____ Preferred Name: _____
Last Name First Name Middle Initial

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____

The best way to contact me is through: □ Text □ Email □ Cell □ Home □ Work □ No preference

Home Address: _____

City: _____ State: _____ Zip: _____

DOB: _____ /_____ /_____ Social Security #: _____ □ Male □ Female / □ Single □ Married
MM DD YYYY

Employer: _____ Spouse Name:_____ Spouse's Employer: _____

Alternate Contact (Outside of Home/Spouse): _____

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

PERSON RESPONSIBLE FOR ACCOUNT: _____ Address: _____

Method of Payment (After Insurance Payments): □ Cash/Check □ Credit Card □ Third Party Financing

PRIMARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group # _____ ID# _____

SECONDARY DENTAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group # _____ ID# _____

MEDICAL INSURANCE: Company Name: _____

Subscriber's Name: _____ DOB: _____ /_____ /_____

Group # _____ ID# _____

I authorize treatment by Dental Care of Vashon and agree to pay all related professional fees. Fees not covered by my dental/medical insurance will be promptly paid upon notification from this office. I have received a copy of the office's financial policy and without reservation I agree to abide by the policies outlined herein.

Signature: _____ Date: _____

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HEALTH HISTORY FORM

Patient Name: _____ Date of Birth: _____

Physician's name, phone, and date of last exam: _____

Yes No Do you take medications? If so, please list: _____

_____

Yes No Do you have allergies (Penicillin, Codeine, Latex, etc.)? If so, please list: _____

Yes No Have you been hospitalized? If so, please list dates and reasons: _____

Do you have or have you ever had any of the following (if "Yes", please circle which):

Yes No Artificial joints (hip, knee, etc.)
Yes No High blood pressure / Angina / Arrhythmias
Yes No Heart disease / Heart attack / Defibrillator
Yes No Artificial heart valve / Pacemaker
Yes No Bleeding disorders / Prolonged bleeding
Yes No Anemia / Leukemia / Blood dyscrasias
Yes No Stroke / Aneurysm
Yes No Seizures
Yes No Hepatitis / Liver disease / Kidney problems
Yes No HIV / AIDS
Yes No Ulcers / Stomach problems
Yes No Osteoporosis / Bone disease
Yes No Diabetes / Family History of Diabetes
Yes No Thyroid / Adrenal problems

Yes No Periodontal (gum) disease
Yes No Family history of periodontal disease
Yes No Cancer / Tumors
Yes No Chemotherapy / Radiation treatment
Yes No Sinus problems / Ear problems
Yes No Asthma / Tuberculosis / Lung disease
Yes No Arthritis / Lupus
Yes No Anxiety / Depression / Psychiatric treatment
Yes No Dental anxiety
Yes No Sleep Apnea
Yes No TMJ Pain / Disorder
Yes No Tobacco use
Yes No Drug / Alcohol abuse
Yes No Currently Pregnant / Nursing

Yes No Any other medical problems? If so, please describe: _____

Yes No Do you prefer some form of sedation for dental procedures? If "Yes", please circle which
Nitrous oxide (laughing gas) Oral sedation IV sedation

Yes No Is there anything you would like to change about your smile/teeth? _____

How often do you: brush your teeth_____ floss your teeth_____

To the best of my knowledge, I have filled out this Health History Form completely and accurately.

Patient / Guardian Signature: _____ Date: _____

Hygienist/Assistant Signature: _____ Date: _____

Doctor Signature: _____ Date: _____

Revised: 08/03/2013

APNEA SCREENING QUESTIONNAIRE

This questionnaire helps to determine your risk for having sleep apnea.

PATIENT NAME:	DATE OF BIRTH:	TODAY'S DATE:

	YES	NO	NOT SURE
Have you ever had a sleep study? If so, When? _____	□	□	□
Were you diagnosed with Obstructive Sleep Apnea?	□	□	□
Are you currently using a CPAP device?	□	□	□

	YES	NO	NOT SURE
Have you been told that (or noticed on your own) that you snore on most nights?	□	□	□
Have you been told (or noticed on your own) that you stop breathing or struggle to breathe in your sleep?	□	□	□
Are you tired, fatigued or sleepy on most days?	□	□	□
Do you have □ **acid indigestion** or □ **high blood pressure** (or use medication to control either of these conditions?)	□	□	□
Are you overweight?	□	□	□
Do you have diabetes?	□	□	□
Have you ever been told you have any of the following?:	□	□	□

- □ Congestive Heart Failure
- □ Coronary Artery Disease
- □ Irregular Heart Rhythms (atrial fibrillation)
- □ Stroke □ Other _____

Internal Office Notes:

Height: _____ Weight: _____ BMI: _____ Neck Circumference: _____

Insurance: _____ Requires Prior Auth.? Y / N Screener Score: _____

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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 would like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.

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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 Dental Care of Vashon. 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.

Dental Care of Vashon 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**
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: **Date:**		

FOR 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:**	