Single _____ Married _____

First MI Last

Name _____ Age _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Home Phone ( ) _____ Business Phone ( ) _____

Cellular Phone ( ) _____ E-mail: _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Spouse's Name _____ Birthdate _____

Employer _____ Occupation _____

Business Address _____ City _____ State _____ Zip _____

Patient Social Security # _____

Spouse Social Security # _____

Person Financially Responsible _____ Relationship _____

Do you have dental insurance coverage? _____ Yes _____ No

If Yes, Name of Insured (Employee) _____

Name of Insurance Company _____

Group # _____ ID # _____ Union # _____

Do you have more than one dental insurance company? _____ Yes _____ No

If Yes, Name of Insured (Employee) _____

Name of Insurance Company _____

Group # _____ ID # _____ Union # _____

In case of emergency, who should we contact? _____ Phone ( ) _____

Whom may we thank for referring you? _____

I understand that my insurance is an agreement between my insurance company and me. I also understand that I am responsible for the balance of my dental account, regardless of my insurance. I assign dental benefit payment to be paid directly to Dr. Mott from my insurance company. I understand that I may incur an 12% annual finance charge if my balance goes beyond 90 days.

Patient Signature _____ Date _____

Bradley S. Mott, D.D.S.

MEDICAL HISTORY

PATIENT NAME _____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics ☐ Acrylic ☐ Metal ☐ Latex ☐ Sulfa drugs

☐ Other If yes, please explain: _____

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

_____

SIGNATURE OF PATIENT, PARENT, or GUARDIAN _____ DATE _____

DENTAL HISTORY

Previous Dentist_____ Last Dental Exam_____

Last Dental Treatment_____ Last Dental X-Rays_____

How Often do you have your teeth cleaned? 3mo_____ 4mo_____ 6mo_____ 1yr or longer_____
Do you use dental floss? Yes___ No____ If yes, how often_____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?_____

_____

Please check if you have, or have ever had the following: → If yes, please explain;

1.	Unhappy with appearance of your teeth	Y__	N__	_____
2.	Unfavorable dental experience	Y__	N__	_____
3.	Dental Fears	Y__	N__	_____
4.	Preference for no anesthetic	Y__	N__	_____
5.	Probs. w/effect or reactions to anesthetic	Y__	N__	_____
6.	Orthodontic treatment	Y__	N__	_____
7.	Periodontal (gum) treatment	Y__	N__	_____
8.	Bleeding gums	Y__	N__	_____
9.	Avoid brushing any part of your mouth	Y__	N__	_____
10.	Part of your mouth is sensitive to pressure	Y__	N__	_____
11.	Sore teeth	Y__	N__	_____
12.	A burning sensation in your mouth	Y__	N__	_____
13.	Difficulty swallowing	Y__	N__	_____
14.	An unpleasant taste or odor in your mouth	Y__	N__	_____
15.	Jaw problems (Temporomandibular joint)...	Y__	N__	_____
16.	Difficulty opening your mouth widely	Y__	N__	_____
17.	Stiff neck muscles	Y__	N__	_____
18.	Wake up with pain in jaws or teeth	Y__	N__	_____
19.	Tension headaches	Y__	N__	_____
20.	Clench or grind your teeth'	Y__	N__	_____
21.	Jaw Clicking or popping	Y__	N__	_____
22.	Lost any teeth	Y__	N__	_____

SUPPLEMENTAL DENTAL HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

1.	Has your present denture been relined?	Yes____	No____
2.	Is your present denture a problem?	Yes____	No____
3.	Are you satisfied with the appearance?	Yes____	No____
4.	Are you satisfied with the comfort?	Yes____	No____
5.	Are you satisfied with your chewing ability?	Yes____	No____

- When did you receive your first partial or complete denture?_____
- How long have you worn your present denture?_____

NOTICE OF PRIVACY PRACTICES

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 all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to 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 law, 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 your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information 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 use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings in response to a subpoena or court order to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect or domestic violence. Any other uses and disclosures 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 regard to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address below:

- The right to request restrictions on certain uses 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 at alternative locations.
- The right to access, inspect and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment or health care operations...or based on your previous authorization.
- 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 is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices in effect. We reserve the right to change the terms of our 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. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices:
Contact: Brandi Johnson
c/o Bradley Mott, DDS, PLLC
6507 NE 181st Street, Kenmore, WA 98028
(425) 486-9211

For more information on HIPAA or to file complaint:
U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue S.W., Washington, D.C. 20201
(877) 696-6775 (toll-free)

ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES

Bradley S. Mott, DDS
6507 NE 181st Street
Kenmore, WA 98028
(425)486-9211

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 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 address above 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 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:

____

____

- -

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

OFFICE POLICIES:

We recognize the value of your time. Except in emergency situations, you can expect us to be on time for you. We would appreciate the same courtesy. Please allow enough time in your busy schedule to arrive on-time for your appointment. Failure to do so results not only in a disruption of the Doctor & Hygienist's schedules for the remainder of the day but inconvenience to all patients scheduled after you.

We require 48 hours notice to cancel or re-schedule an appointment. This allows us sufficient time to fill the opening. Having a full schedule allows us to continue to provide our services at reasonable fees which will benefit us all in the end. Failure to provide 48 hours notice will result in a **$50** fee per hour cancelled.

In today's economy we understand the need for open communication concerning treatment costs. Whenever new treatment is recommended we will provide you with a written estimate showing the treatment, the amount we estimate your insurance will pay and an estimate of your patient responsibility. It is our policy to collect the Patient Responsibility **AT THE TIME OF TREATMENT.** We accept cash, checks, VISA & MasterCard. For large Treatment Plans we offer ***CareCredit*** with no-interest or low-interest plans for your convenience.

It is your responsibility to keep our office updated should your insurance change. Please remember to provide new DENTAL insurance information at least one week prior to your scheduled visit. Please do NOT provide MEDICAL/VISION/RX insurance information.

I have reviewed the Office Policies and agree to abide by the terms therein.

_____ _____

SIGNATURE DATE

Bradley S. Mott, D.D.S. ** 6507 NE 181st Street, Kenmore, WA ** (425) 486-9211