Kenmore Smiles
FAMILY DENTISTRY

Today's Date: _____

Patient Information

Name (First and Last) _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Best Time to Contact: _____

Emergency Contact: Name: _____ Phone Number: _____

How did you learn about our practice and whom may we thank for referring you?

_____

Person responsible for your account and payment (if different from above):

_____

Insurance Information

Dental Insurance:

Insurance Company: _____ Insurance Co. Phone Number: _____

Insurance Address: _____

ID # _____ Group # _____ Employer Name: _____

Subscriber Information (If Different From Patient):

Subscriber Name: _____ Birthdate: _____SSN: _____

Secondary Insurance (If Applicable):

Dental Insurance:

Insurance Company: _____ Insurance Address: _____

Insurance Company Phone Number: _____

ID # _____ Group # _____ Employer Name: _____

Subscriber Information (If Different From Patient):

Subscriber Name: _____ Birthdate: _____ SSN: _____

Patient / Guardian Signature: _____

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PATIENT DENTAL HISTORY

Please complete both sides of this dental/medical history form so that we may provide you with the best possible dental care. ***All information is completely confidential.***

What is the reason for your visit today?

_____

Last Dental Cleaning _____ Last Full Mouth X-rays _____

Previous Dentist's Name _____

How often do you have dental examinations? _____

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

Do you have any immediate dental problems? ☐ Yes ☐ No If yes, please describe below:

_____

Have you ever been told to take a pre-medication (antibiotic) prior to dental treatment? ☐ Yes ☐ No

Is there anything else about having dental treatment that you would like us to know? ☐ Yes ☐ No

If yes, please describe:

_____

Are any of your teeth sensitive to:

Hot or cold?	☐ Yes	☐ No
Sweets?	☐ Yes	☐ No
Biting or chewing?	☐ Yes	☐ No
Have you noticed any mouth odors or bad taste?	☐ Yes	☐ No
Do you frequently get cold sores, blisters or any other oral lesions?	☐ Yes	☐ No
Do your gums bleed or hurt?	☐ Yes	☐ No
Have your parents experienced gum disease or tooth loss?	☐ Yes	☐ No
Have you noticed any loose teeth or change in your bite?	☐ Yes	☐ No
Does food tend to become caught in between your teeth?	☐ Yes	☐ No

If yes, where? _____

Have you experienced:

Clicking or popping of the jaw?	☐ Yes	☐ No
Pain (joint, ear, side of face)?	☐ Yes	☐ No
Difficulty in opening or closing the mouth?	☐ Yes	☐ No
Difficulty in chewing on either side of the mouth?	☐ Yes	☐ No
Headaches, neck aches or shoulder aches?	☐ Yes	☐ No
Sore muscles (neck, shoulders)?	☐ Yes	☐ No

Do you:

Clench or grind your teeth while awake or asleep?	☐ Yes	☐ No
Bite your lips or cheeks regularly?	☐ Yes	☐ No
Hold foreign objects with your teeth (pencils, pipe, pins, nails, fingernails)?	☐ Yes	☐ No
Mouth breathe while awake or asleep?	☐ Yes	☐ No
Have tired jaws, especially in the morning?	☐ Yes	☐ No
Snore or have any other sleeping disorders?	☐ Yes	☐ No
Smoke/chew tobacco or use other tobacco products?	☐ Yes	☐ No
Do you feel nervous about having dental treatment?	☐ Yes	☐ No

If so, what is your biggest concern? _____

Have you ever had an upsetting dental experience?	☐ Yes	☐ No

If yes, please describe _____

Patient / Guardian Signature: _____ **Date:** _____

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PATIENT MEDICAL HISTORY

Physician's Name _____ Phone ( ) _____

Have you had any medical care within the past two years? ☐ Yes ☐ No

Describe:

_____

Have you taken any medication or drugs during the past two years? ☐ Yes ☐ No

Are you currently taking any medication, drugs, pills, including regular dosages of aspirin? ☐ Yes ☐ No

Please list: _____

Are you aware of having an allergic (or adverse) reaction to any substance or medication? ☐ Yes ☐ No

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

☐ Other Please explain: _____

Have you been hospitalized within the past 5 years? ☐ Yes ☐ No Explain: _____

Women: Are you pregnant or think you could be pregnant? ☐ Yes ☐ No _____ Weeks/Months

Nursing? ☐ Yes ☐ No Do you use birth control prescriptions? ☐ Yes ☐ No

Please indicate which of the following you have had or have at present. Check "Yes" or "No" to each item.

Heart (Surgery, Disease, Attack)	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Venereal Disease	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Ulcers	☐ Yes	☐ No	AIDS/HIV Positive	☐ Yes	☐ No
Congenital Heart Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Cold Sores/Fever Blisters	☐ Yes	☐ No
Heart Murmur	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No	Blood Transfusion	☐ Yes	☐ No
High/Low Blood Pressure	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No
Mitral Valve Prolapse	☐ Yes	☐ No	Contact Lenses	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Artificial Heart Valve/ Pacemaker	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Bruise Easily	☐ Yes	☐ No
Rheumatic Fever	☐ Yes	☐ No	Chronic Cough	☐ Yes	☐ No	Liver Disease/Yellow Jaundice	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No
Swollen Ankles	☐ Yes	☐ No	Hay Fever/Allergy/Hives	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No
Stroke	☐ Yes	☐ No	Latex Sensitivity	☐ Yes	☐ No	Nervous/Anxious	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No	Psychiatric/Psychological Care	☐ Yes	☐ No
Artificial Joints (Hip, Knee, etc.)	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No			
			Chemotherapy	☐ Yes	☐ No			
			Tumors	☐ Yes	☐ No			
			Hepatitus A, B, C	☐ A	☐ B	☐ C	☐ N/A	

I understand the above information in necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient / Guardian Signature: _____ **Date:** _____

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: Ilse Corona

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

Dr Bradley Mott, DDS
6821 NE 181st ST Ste. 102
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 t my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Family members also covered by this acknowledgement:

_____

_____

For Office Use Only:
We were unable to obtain the patient's written acknowledgment of our Notice of Privacy Practices due to the following reason:

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

Kenmore Smiles
FAMILY DENTISTRY

PATIENT PRACTICE AGREEMENT & OFFICE POLICIES:

Thank you for choosing our office for your dental needs. Obtaining dental treatment is very important for your overall health. At Kenmore Smiles Family Dentistry, we value your time, and we appreciate that you value ours. Our team is committed to being prepared to meet your specific needs at your scheduled appointment time each day. We respectfully ask for scheduled appointments to be confirmed at least 48 hours in advance. *If you need to cancel or reschedule your appointment, we kindly ask for notice at least 48 hours in advance , or you will be charged a $75 cancellation fee per hour scheduled. Appointment no-shows will be charged at the same rate.*

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. *Please note that any returned checks will incur a $35 additional charge to your account.*

We realize that emergencies can occur. Should an unforeseen situation prevent you from making a pre-arranged payment, please contact our office to avoid the possibility of a misunderstanding.

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. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services and I am responsible for any balance remaining on the account per the provisions of the insurance contract. I understand and agree to pay the late cancel/reschedule/missed appointment fee if it applies to me.

_____ _____

SIGNATURE DATE

Brad S. Mott, DDS
6821 NE 181st ST Ste. 102, Kenmore, WA 98028
(425) 486-9211