Dental History and Consent for Treatment

Reason for seeking dental care at this time_____

Former dentist_____City/State_____

Date of last dental visit_____ Reason_____

How often do you: Brush _____times per _____ Floss_____times per_____

How do you feel about dental treatment?

- ☐ Relaxed
- ☐ A little uneasy
- ☐ Tense
- ☐ Anxious
- ☐ Very anxious

Do you have or have you ever had any of the following? Please mark the boxes and comment

- ☐ Aching or sensitive teeth_____
- ☐ Broken filling_____
- ☐ Areas of food traps_____
- ☐ Unfavorable dental experiences_____
- ☐ Sensitive or bleeding gums_____
- ☐ Loose teeth_____
- ☐ Difficulty opening wide_____
- ☐ Growths or lesions in your mouth_____
- ☐ Broken or missing teeth_____
- ☐ Bad breath_____
- ☐ Clicking or popping jaw_____
- ☐ Cold sores_____
- ☐ Grinding or clenching_____
- ☐ Swollen glands_____
- ☐ Jaw pain or tiredness_____
- ☐ Dry mouth_____
- ☐ Swelling or lumps in mouth_____
- ☐ Gum infections_____
- ☐ Orthodontic treatment_____
- ☐ Other_____

If you could change your smile, what would you change?

- ☐ Remove unsightly fillings
- ☐ Straighten teeth
- ☐ Change shape of teeth
- ☐ Close gaps in teeth
- ☐ Other_____
- ☐ Replace missing teeth
- ☐ Whitening
- ☐ Make teeth same color

Medical Health history

Do you have or have you had any of the following? (check all that apply)

- ☐ Anemia
- ☐ Heart problems, Chest pain, Shortness of breath
- ☐ Blood pressure problems
- ☐ Heart murmur
- ☐ Heart valve issues, Artificial heart valve
- ☐ Rheumatic fever
- ☐ Pacemaker
- ☐ Easy bruising
- ☐ Frequent nosebleeds/Abnormal bleeding
- ☐ Blood disease
- ☐ Ever require a blood transfusion?
- ☐ Allergy problems
- ☐ Hay fever
- ☐ Sinus problems
- ☐ Skin rashes
- ☐ Taking allergy medication
- ☐ Asthma
- ☐ Intestinal problems
- ☐ Ulcers
- ☐ Weight gain or loss
- ☐ Special diet
- ☐ Constipation/diarrhea
- ☐ Kidney or bladder problems
- ☐ Fainting spells, seizures or epilepsy
- ☐ Stroke(s)
- ☐ Frequent or severe headaches
- ☐ Thyroid problems
- ☐ Persistent cough or swollen glands
- ☐ Pre-medication required by physician
- ☐ Cancer/tumor
- ☐ Diabetes
- ☐ Urinate more than six times a day
- ☐ Thirsty or mouth is dry much of the time
- ☐ Family history of diabetes
- ☐ Tuberculosis or other respiratory disease
- ☐ Do you drink alcohol?
  >If so, how much? _____
- ☐ Hepatitis, jaundice or liver trouble
- ☐ Herpes or other STD
- ☐ HIV positive/AIDS
- ☐ Glaucoma
- ☐ Do you wear contact lenses?
- ☐ Head injury
- ☐ Epilepsy or other neurologic disease
- ☐ History of alcohol or drug abuse

During the last 12 months, have you taken any of the following?

- ☐ Antibiotics or sulfa drugs
- ☐ Anticoagulants (e.g., Coumadin)
- ☐ High blood pressure medication
- ☐ Tranquilizers
- ☐ Insulin, Orinase or similar drug
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Nitroglycerin
- ☐ Cortisone (steroids)
- ☐ Natural remedies
- ☐ Nonprescription drug/supplements
- ☐ **Please list all current medications**_____

_____

_____

Are you allergic or have you reacted adversely, to any of the following?

- ☐ Local anesthetics (“Novocaine”)
- ☐ Penicillin or other antibiotics
- ☐ Sulfa drugs
- ☐ Barbiturates, sedatives or sleeping pills
- ☐ Aspirin, acetaminophen or ibuprofen
- ☐ Codeine, Demerol or other narcotics
- ☐ Metals
- ☐ Latex or rubber dam
- ☐ Other_____

Women

- ☐ Are you taking contraceptives or other hormones?
- ☐ Are you pregnant?
  If so, expected delivery date? _____
- ☐ Are you nursing?
- ☐ Have you reached menopause?

Patient Signature_____

Date_____

750 George Washington Way, Suite 3
Richland, WA, 99352
(509)946-4848

I, _____, Date of Birth:_____, request and authorize the release of my dental records to Dr. Benjamin Walker, DMD, at Walker Family Dental.

Please email information to:

office@walkersmiles.com

Or mail to:

Walker Family Dental
750 George Washington Way, Suite 3
Richland, WA 99352

Patient Signature:_____Date:_____

Acknowledgement of Receipt of Notice of Privacy Practices

Walker Family Dental
750 George Washington Way #3
Richland, WA 99352

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.* Importantly, the updated 9/23/2013 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 the acknowledgement_____

_____

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)
OTHER-SPECIFY Name Relationship

_____

_____

_____

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

Patient Information Date:_____ Referred By:_____

Full Name _____Preferred Name:_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone _____ Text? Y or N

Sex: M ☐ F ☐ Married ☐ Single ☐ Age _____ Birthdate _____

Email _____

Name of friend of relative who can be reached in case of emergency:

Name _____ Phone _____

Responsible Party

Person Responsible for Account _____

Relationship to Patient _____Birthdate _____Social Security # _____

Address (if different from patient) _____ Home Phone # _____

City _____ State _____ Zip code _____

Employer _____ Work Phone _____

Insurance Information

Name of Insured _____

Birthdate _____ Social Security # _____ Relationship to patient _____

Name of Employer _____

Address of Employer _____City _____State _____Zip _____

Insurance Company_____ Group # _____

Insurance Address_____ City_____ State _____ Zip_____

Do you have additional insurance Yes ☐ No ☐ If yes, complete the following:

Name of Insured _____

Birthdate _____ Social Security # _____ Relationship to patient _____

Name of Employer _____

Address of Employer _____ City _____ State _____ Zip_____

Insurance Company _____ Group # _____

Insurance Address _____ City _____ State _____ Zip _____

Please read carefully: In order to prevent a misunderstanding about our fees and Dental Insurance, we wish our patients to know that;

A. Your insurance is a contract between you and your insurance company. You are liable for the bill, not your insurance company

B. In most cases your insurance will pay only part of our fees. Since our relationship is with you, our bill is your personal responsibility.

Statement of Financial Responsibility: If it is necessary to employ an attorney or collection agency to collect balances due for services rendered by Walker Family Dental, I agree to pay, in addition to the principal amount then owing, all other lawful charges, costs and expenses of collection, including reasonable attorney's fees. If in the event suitable for legal action becomes necessary, venue shall be in Benton County.

Date _____ Signature _____

Walker
FAMILY DENTAL

Financial Policy Acknowledgement

Thank you for choosing our office for your dental care. We are committed to providing you with the highest quality of dentistry and we offer a variety of financial options to enable you to receive the dental care you need. We accept cash, check, VISA, MasterCard, Discover and American Express. We have also partnered with third-party companies to offer the flexibility of deferred interest and extended payment options.

We are committed to respecting your time and ask that you make every effort to keep the appointment time reserved for you. Should you need to change your appointment, we ask that you give us 48 hour notice. Missed appointments leave a void in our schedule and may be subject to a missed appointment fee.

It is our policy to ask for payment at time of service. Limited payment plans are considered by individual case. Please ask if you need more information.

Patients without dental insurance are offered a 5% discount for payment in full at time of service; 10% for ages 65 or older.

As a courtesy to our patients with dental insurance benefits, we will submit your claim and provide any necessary information to assist you in receiving your dental benefits. Unless paying with Care Credit or FSA/HSA, it is our policy to ask for patient portion at time of service. For major services and extensive treatment plans, we ask for a deposit of half of the estimated patient portion at time of service and the balance after insurance pays.

If needed, please contact your dental insurance carrier prior to your visit to obtain essential information which will accurately reflect your coverage. Providing us with this information will expedite the processing of claims.

Important Facts about your Dental Insurance

- Dental insurance is a contract between the patient and the insurance company. It is a benefit to assist you with the cost of dental care. At no time should insurance benefits compromise your doctor's diagnosis or affect your choice of treatment.
- It is your responsibility to understand the type of dental insurance you have and the benefits selected by you and/or your employer.
- You (not the insurance company) are responsible for the fees of services rendered.

Additional notes:
A delinquent account impedes our ability to provide you with the quality dental care that you deserve.
We will communicate recommended treatment options, associated fees and expected financial arrangements prior to the start of treatment.
It is our policy that the parent or guardian who accompanies a child to our office for treatment is responsible for payment of all services rendered.

Patient/Parent/Guardian Signature:_____Date:_____

Walker Family Dental
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in the Notice while it is in effect. This Notice takes effect June 20, 2016, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of the Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of the Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of a patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about

you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Other Uses and disclosures of PHI

We do not foresee additional purposes for disclosing your PHI other than those provided for in this Notice (or as otherwise permitted or required by law). If such a purpose should arise, we will obtain your written authorization before using or disclosing your PHI. You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Access. You have the right to view or obtain copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by the using the contact information listed at the end of the Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you the the right to an electronic copy. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with the applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restriction on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to you request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or locations, and provide satisfactory explanation of how payments will be handled under alternative means or locations you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of the Notice upon request, even if you have agreed to this Notice electronically on our website or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information, you may complain to us using the contact information listed at the end of the Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint to the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Our Privacy Official: Marie Waite
Telephone: 509-946-4848 Fax: 509-946-5906
Address: 750 George Washington Way, Suite 3, Richland, WA 99352
Email: walkerfamilysmiles@gmail.com