SEATTLE'S Capitol Hill DENTIST

Patient's Information

Full Legal Name: _____

_____

Preferred Name: _____

Preferred Pronoun: ☐ He ☐ She ☐ They ☐ _____

Date of Birth: _____ ☐ male ☐ female

Home Address: _____

_____

City/State: _____Zip:_____

Social Security #:_____

Cellphone #:_____

Home #: _____

Work #: _____

Email: _____

Which is the best way to reach you?

☐ Phone call ☐ Email ☐ Text ☐ Home # ☐ Work #

How did you hear about us?

☐ Google ☐ Bing ☐ YELP ☐ Insurance Search ☐ Other

☐ Friend : _____

What Keywords did you use to find us?

☐ Seattle Dentist ☐ Emergency Dentist

☐ other :_____

Emergency Contact

Name: _____

Phone #: _____

Relationship: _____

Dental Insurance Information

☐ I will not be using dental insurance at this time.

Policy Holder: _____

Employer: _____

Date of Birth: _____

Insurance Provider: _____

ID #: _____

Group #: _____

Secondary Insurance Information

Policy Holder: _____

Employer: _____

Date of Birth: _____

Insurance Provider: _____

ID #: _____

Group #: _____

I understand that I am responsible for informing Seattle's Capitol Hill Dentist of changes to my insurance information. I hereby authorize payment directly to Seattle's Capitol Hill Dentist for the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient Name (Print) : _____

Patient Signature: _____ **Date:** _____

CONTINUE TO NEXT PAGE →

SEATTLE'S CAPITOL HILL DENTIST MEDICAL HISTORY FORM

1. Are you under medical treatment now? _____YES NO
   If so, what? _____
2. Have you been hospitalized for any surgical operations or serious illness? _____YES NO
   If so, what? _____
3. Are you taking any medicines including non-prescription medicine? _____YES NO
   If so, what? _____
4. Are you required to pre-medicate before dental treatment? _____YES NO
   If so, what? _____

Treating Physician's Name : _____ Phone Number _____
Date of Last physical Exam : _____

Allergies to Medicines

Are you allergic to or have you had any reactions to the following?

☐ **NO KNOWN ALLERGIES**

□ Aspirin
□ Barbiturates
□ Codeine
□ Ibuprofen
□ Latex
□ Local Anesthetics (i.e. Novocain)
□ Penicillin / Amoxicillin
□ Sedatives
□ Sulfa Drugs
□ Other _____

Medical Conditions

Please check the boxes if you have or have had any of the following

□ AIDS / HIV Infection
□ Anemia
□ Angina / Chest Pains
□ Anxiety with dental care
□ Asthma
□ Cancer / Radiation Therapy
□ Cardiac Pacemaker
□ Diabetes
□ Emphysema
□ Epilepsy / Convulsions
□ Fainting / Seizures
□ Have you been treated for Alcohol or Chemical dependency?
□ Hay Fever / Seasonal Allergies
□ Heart Attack / Heart Disease
□ Heart Murmur
□ Hepatitis / Jaundice
□ High Blood Pressure
□ Intestinal Disease
□ Joint Replacement / Implants / Screws / Pins
□ Kidney / Liver Disease
□ Leukemia
□ Low Blood Pressure
□ Mitral Valve Prolapse
□ Night Sweats accompanied by weight loss or cough
□ Recent Weight Loss
□ Respiratory Problems
□ Rheumatic Fever
□ Stomach Troubles / Ulcers
□ Stroke
□ Thyroid Problems
□ Tuberculosis
□ Tumors or Growths
□ Weight Reduction Surgery
□ Wounds that heal slowly or present with other complications

WOMEN **:** □ Taking Birth Control Pills □ Nursing □ Pregnant or think you may be pregnant (due date : _____)

What is your main reason for visiting Seattle's Capitol Hill Dentist?

□ General checkup □ Emergency visit □ Consultation □ Other : _____

Patient Name (Print) : _____

Patient Signature: _____ **Date:** _____

CONTINUE TO NEXT PAGE →

SEATTLE'S CAPITOL HILL DENTIST FINANCIAL POLICY

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Thank you for choosing Seattle's Capitol Hill Dentist as your dental health care provider. It is our commitment to provide quality care to our patients and avoid misunderstandings. At this time, we would like to inform you of our office policy regarding payment for services rendered.

All fees, including co-payments and deductibles, are due at the time of service. For your convenience we accept the following forms of payment: cash and credit cards. We also offer Care Credit Financing that allows you to pay with interest free monthly payments. For more information please ask our front office staff.

Our office will bill your insurance company as a courtesy to you. We will provide you with an insurance estimate prior to any treatment being performed. This is just an estimate and the amount the insurance company pays may be different than what we have estimated. **If for any reason your insurance does not pay the estimated amount, you will become responsible for the balance.**

Sometimes treatment may differ from the proposed treatment plan that you were given during the examination appointment. You will be informed of any of these unforeseen changes and given a new estimate.

SEATTLE'S CAPITOL HILL DENTIST APPOINTMENT POLICY

If you cannot come to your scheduled dental appointment, **please call the office at least 48 hours prior** to the appointment (2 business days). This allows us to fill the appointment with another patient. Please be on time for your appointment, if you are more than 15 minutes late we may have to reschedule your appointment to another day.

ALL APPOINTMENTS CANCELLED WITHOUT 48 HOURS (2 BUSINESS DAYS) NOTICE CARRY A MISSED APPOINTMENT FEE OF $100 PER SCHEDULED HOUR.

I have read and understand both the financial policy and missed/cancelled appointment policy above for Seattle's Capitol Hill Dentist.

Patient Name (Print) : _____

Patient Signature: _____ **Date:** _____

CONTINUE TO NEXT PAGE →

SEATTLE'S CAPITOL HILL DENTIST
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a written copy of our Notice of Privacy Practices at any time by contacting:
Contact Officer: Stephanie Sauvage
Telephone: 206-283-9278

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took prior to your revocation.

I, as the Patient or the Patient's Representative, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

☐ **ANY MEMBER OF MY IMMEDIATE FAMILY** ☐ **SPOUSE / PARTNER ONLY** ☐**OTHER** _____

Patient Name (Print) : _____

Patient Signature: _____ **Date:** _____

(If this Consent is signed by a Personal Representative on behalf of the patient, please complete the following)
Representative's Name : (print) _____ Relationship to Patient : _____

Representative's Signature : _____ Date: _____

STOP HERE – READ BELOW
Please complete the following ONLY if you would like a copy of this form. You are entitled to a copy.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

Patient's Name: (print) _____ Date_____

Patient's Signature: _____

I, (Print signature name, if signing as Representative) _____, have received a copy of this office's Notice of Privacy Practices. Signature of Representative_____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

___ Individual refused to sign
___An emergency situation prevented us from obtaining acknowledgment
__ Communication barriers prohibited obtaining the acknowledgement
__Other (Please specify) _____