FOREVER SMILES
FAMILY DENTAL

Patient Registration Form – Tell Us About Yourself

Thank you in advance for your coming to see us today. In order for us to better serve you, please take a few moments to complete this entire form. At Forever Smiles Family Dental, we are committed to keeping your private healthcare information confidential.

Name: _____
Last First MI Title

Preferred Name: _____ ☐ Male ☐ Female
Address: _____ City _____ State _____ ZIP_____
SSN: _____ DOB: _____
Home Phone:_____ Work Phone:_____
Cell Phone:_____ E-mail Address:_____
Employer:_____ Occupation: _____
Marital Status: ☐Single ☐ Married ☐ Divorced ☐Widowed ☐ Separated ☐Domestic Partner

How did you hear about our office? _____
Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____ *(Please circle preference)*

■ Insurance – Primary ■

Subscriber Name: _____Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address:_____
Insurance Company Phone: _____Group Number: _____

■ Insurance – Secondary ■

Subscriber Name: _____ Relationship to Patient: _____ Subscriber DOB: _____
Subscriber SSN/ID: _____ Subscriber Employer: _____
Insurance Company Name: _____
Insurance Company Address: _____
Insurance Company Phone: _____ Group Number: _____

■ Assignment and Release ■

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Forever Smiles Family Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____

Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____

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FAMILY DENTAL

Medical History

Thank you for filling out this form completely. It will enable our office to be more effective in meeting your needs. If you have any questions at any time, please ask us. We will be happy to help.

Do you have a personal physician? ❑ Yes ❑ No
Physician's Name: _____
Address: _____
City State Zip
Phone #: ( )_____
Date of last visit: _____
Your current physical health is: ❑ Good ❑ Fair ❑ Poor
Are you currently under the care of a physician? ❑ Yes ❑ No
Please explain: _____
_____
Do you smoke or use tobacco in any other form? ❑ Yes ❑ No
Have you had any metal rods, pins or implants placed? ❑ Yes ❑ No
Have you ever had a blood transfusion? ❑ Yes ❑ No
Have you ever taken PhenPhen/Fosamax? ❑ Yes ❑ No

Are you Allergic to any of the following?

Y N Aspirin	Y N Erythromycin	Y N Penicillin
Y N Barbiturates	Y N Jewelry	Y N Seasonal
Y N Codeine	Y N Latex	Y N Sulfa Drugs
Y N Dental Anesthetics	Y N Other _____	

Please list additional drugs that cause allergic reactions: _____
_____
_____
For Women: Are you taking birth control pills? ❑ Yes ❑ No
Are you pregnant? ❑ Unsure ❑Yes, week #_____ ❑ No
Are you nursing? ❑ Yes ❑ No

Are you taking any prescriptions or over-the-counter drugs? ❑ Yes ❑ No
If yes, please list each one: _____

Have you experienced the following diseases or medical conditions?

Y	N	Abnormal Bleeding	Y	N	Emphysema	Y	N	Liver Disease
Y	N	Alcohol Abuse/Drug Abuse	Y	N	Epilepsy/Seizures	Y	N	Mitral Valve Prolapse
Y	N	Anemia	Y	N	Fainting Spells	Y	N	Pacemaker
Y	N	Arthritis	Y	N	Frequent/Severe Headaches	Y	N	Persistent Cough
Y	N	Artificial Bones/Joints	Y	N	Glaucoma	Y	N	Psychiatric Problems
Y	N	Artificial Heart Valves	Y	N	Hay Fever	Y	N	Radiation Treatment
Y	N	Asthma	Y	N	Heart Attack	Y	N	Rheumatic Fever
Y	N	Blood Transfusion	Y	N	Heart Murmur	Y	N	Scarlet Fever
Y	N	Cancer	Y	N	Heart Surgery	Y	N	Sinus Problems
Y	N	Chemotherapy	Y	N	Hepatitis Type_____	Y	N	Steroid Problems
Y	N	Colitis/Ulcers	Y	N	Herpes/Fever Blisters	Y	N	Stroke
Y	N	Congenital Heart Defect	Y	N	High/Low Blood Pressure	Y	N	Thyroid Problems
Y	N	Diabetes	Y	N	HIV+/AIDS	Y	N	Tuberculosis (TB)
Y	N	Difficulty Breathing	Y	N	Kidney Problems	Y	N	Venereal Disease

Please list any hospitalizations or major surgeries in the last five years: _____
_____

List any serious medical condition(s) that you have experienced (not listed above): _____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature: _____ Date: _____

Dental History

How may we help you today? _____
Your current dental health is: ❑ Good ❑ Fair ❑ Poor
When was your last dental cleaning? _____
Did you have x-rays at that time? ❑ Yes ❑ No
Do you require antibiotics before dental treatment?
❑ Yes ❑ No
Are you currently in pain? ❑ Yes ❑ No
Do your gums bleed? ❑ Yes ❑ No
Have you ever had gum disease? ❑ Yes ❑ No
Have you ever had rootplaning or a deeper cleaning?
❑ Yes ❑ No
Does food get caught between your teeth? ❑ Yes ❑ No
Have you ever had a serious/difficult problem with any previous dental work? ❑ Yes ❑ No
Do you or have you ever experienced pain/discomfort in your jaw Joint (TMJ/TMD)? ❑ Yes ❑ No
Are you aware of any clenching or grinding? ❑ Yes ❑ No
Do you have frequent headaches? ❑ Yes ❑ No
Do you have any problems eating certain foods?
❑ Yes ❑No If yes, what? _____

Do you still have your wisdom teeth? ❑ Yes ❑ No
Do you have mobility in your teeth? ❑ Yes ❑ No
Have you lost any teeth? ❑ Yes ❑ No
Do you like your smile? ❑ Yes ❑ No
Is there anything you would like to change about your smile?
❑ Yes ❑ No
Are you happy with the color of your teeth? ❑ Yes ❑ No
Are your teeth sensitive to head, cold or anything else?
❑ Yes ❑ No If yes, what?_____
Have you ever had any unfavorable dental experiences?
❑ Yes ❑ No
Why did you leave your previous dentist?
_____
How can we accommodate you better during your dental visit?_____

For Office Use Only

I verbally reviewed the medical/dental information above with the patient named herein. Initials: _____ Date: _____
Doctor's Comments: _____
_____
_____

Medical History Update:

1. Date:_____ Comments:_____ Signature: _____
2. Date:_____ Comments:_____ Signature: _____
3. Date:_____ Comments:_____ Signature: _____
4. Date:_____ Comments:_____ Signature: _____
5. Date:_____ Comments:_____ Signature: _____
6. Date:_____ Comments:_____ Signature: _____
7. Date:_____ Comments:_____ Signature: _____
8. Date:_____ Comments:_____ Signature: _____
9. Date:_____ Comments:_____ Signature: _____
10. Date:_____ Comments:_____ Signature: _____

Forever Smiles Family Dental
4528 W. 26th Ave. Suite 110 Kennewick, WA 99338
Phone: (509) 591-4267

Forever Smiles Family Dental
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.

Advanced Dentistry of Mount Pleasant, hereafter referred to as "Practice," is committed to preserving the privacy and confidentiality of your health information. This Notice of Privacy Practices (NPP) describes how we may use and disclose your protected health information, hereafter referred to as "PHI," to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. 45 CFR§ 164.520. This Notice has been revised to conform to HIPAA's Final Rule referred to as the "Omnibus Rule" published 01/25/13. This notice replaces previous versions of the Notice and is effective 6/1/18. You may access or obtain a copy according to the following options: 1) our website at www.foreversmileswa.com 2) contact the office and request a copy to be sent to you by mail or email, 3) request a copy at the time of your next appointment.

1. USES & DISCLOSURES OF PHI. How We Use Your Information: Your PHI may be used and disclosed by our Practice's provider, administrative and or clinical staff and others outside of our Practice who are involved in your care and treatment for the purpose of providing healthcare services to you.

A) Treatment: We will use and disclose your PHI to provide, coordinate or manage your care and any related services. We may disclose PHI to other providers who may be treating you such as a specialist.

B) Payment: We will use your PHI to obtain payment for the services provided by this Practice. For example, if we are working with your insurance plan, we may verify eligibility or coverage for benefit determination. We may use or disclose your information so that a bill may be sent to you that may include services provided.

C) Healthcare Operations: The Practice may use or disclose, as needed, your PHI in order to support its business activities such as quality performance reviews regarding our services or the performance of our staff.

i) Business Associates: We may share your PHI with third party business associates such as answering services, transcriptionists, billing services, consultants, trainers and legal counsel. We obtain a written agreement with business associates to assure the protection and privacy of your PHI.

<u>Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object:</u> We may use or disclose your PHI in the following situations without your authorization or providing you the opportunity to agree or object as follows:

D) Required or Permitted by Law: We may use or disclose your PHI as required by law. This may include public health activities such as controlling a communicable disease or compliance with health oversight agencies authorized by law. We may disclose PHI to a public health authority authorized to receive reports of child abuse or neglect. We may disclose your PHI if we believe you have been a victim of abuse, neglect or domestic violence to a governmental agency authorized to receive such information in compliance with state and federal law. We may disclose your PHI to the Food and Drug Administration for the quality, safety, or effectiveness of FDA-regulated products or activities. We may disclose your PHI in the course of a legal proceeding in response to a subpoena, discovery request or other lawful process. We may also disclose PHI to law enforcement providing applicable legal requirements are satisfied. We may disclose PHI to a coroner or medical examiner for identification purposes. We may disclose PHI to researchers when the information does not directly identify you as the source of the information and such research has been approved by an institutional review board to ensure the privacy of the PHI. We may disclose PHI as authorized to comply with workers' compensation laws. We may use and disclose your PHI if you are an inmate of a correctional facility and this information is necessary for your care.

Authorization for Other Uses and Disclosures of PHI: Use and disclosure of your PHI not addressed in this Notice of Privacy Practices will be made only with your written authorization. You may revoke this authorization in writing at any time. If you revoke this authorization, we will no longer use or disclose your PHI; however, we are unable to retrieve previous disclosures made with your prior authorization.

Other Permitted and Required Uses and Disclosures that Require Your Permission or Objection:

E) Students: We may share PHI with students working in our Practice to fulfill their educational requirements. If you do not wish a student to observe or participate in your care, please notify your provider.

F) Appointment Reminders: We may contact you as a reminder of your appointment. Only limited information is provided on an answering machine or an individual other than you answering the call. We may issue a post card or letter notifying you that it is time to make an appointment. You may provide a preferred means of contact such as a mobile telephone number or email address. Reasonable requests will be accommodated.

G) Family, Close Friends, Personal Representatives & Care Givers: Our staff may disclose to person involved in your care your PHI relevant to that person's involvement in your care or payment of the services providing you identify these individual(s) and authorize the release of information. If you are unable to agree or object to such disclosure, we may disclosure such information as necessary if we determine that it is in your best interest based on our professional judgment. If a young adult age eighteen (18)

requests that his or her information not be released to a parent or guardian, we must comply with this request in compliance with state law. For minor children living in divided households, both parents (mother and father) have access to the PHI unless their parental rights have been terminated. Payment of services is addressed in your Final Divorce Decree; however, we obtain payment from the parent who brings the child in for treatment. We will provide you a statement to send to the other parent for your reimbursement.

H) Disaster Relief: If applicable, we may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your care.

2. YOUR RIGHTS. The following is a statement of your rights regarding PHI we gather about you:

A) Copy of this Notice: You have the right to a copy of this notice including a paper copy.

B) Inspect and Copy PHI: You have the right to inspect and obtain a copy of PHI about you maintained by our Practice to include patient and billing records. You must submit a written request and indicate whether you prefer a paper or electronic copy. According to state and federal law, we may charge you a reasonable fee to copy your records. Our Practice does not transmit unsecure PHI via email. However, if you prefer this information emailed to you with encryption or security measures, we will comply with your request and will verify your email address. We suggest sending our Practice an email and we will reply with the attachment. (Note: Under federal law, you may not inspect or copy psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding. Please contact the Privacy Officer for more details).

C) Amendment: You have the right to have your provider amend your PHI about you in a designated record set. Please consult with the Privacy Officer. We may deny this request and you may respond with a statement. We may include a rebuttal statement in your record. Reasons we may deny amending such information, but not limited to these reasons, is if we did not create the information, or if the individual who created the information is no longer available to make the amendment or it is not part of the information maintained at our Practice.

D) Restrictions: You have the right to request a restriction of your PHI. If you paid out-of-pocket for a service or item, you have the right to request that information not be disclosed to a health plan for purposes of payment or health care operations and we are required to honor that request. You may request in writing to our Privacy Officer not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations such as to family members or friends involved in your care or for notification purposes as described in this Notice of Privacy Practices. However, your provider is not required to agree to this restriction. You may discuss restrictions with the Privacy Officer.

E) Confidential Communications: You have the right to request to receive confidential communications from our Practice by alternative means or at an alternative location. For example, you may prefer our Practice to use your mobile telephone or email rather than a residential line. Please make this request in writing to the Privacy Officer. Our staff will not ask personal questions regarding your request.

F) Disclosures: You have the right to request an accounting of disclosures of your PHI including those made through a Business Associate as set forth in CFR 45 § 164.528. The HITECH Act removed the accounting of disclosures exception to PHI to carry out treatment, payment and healthcare operations if such disclosures are made through the EHR. To request an accounting, submit your request in writing to the Privacy Officer.

G) Breach Notification: According to the HITECH Act, you have the right to be notified following a breach of unsecured PHI that affects you. "Unsecured" is information that is not secured through the use of technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the PHI unusable, unreadable and undecipherable to unauthorized users. Breach notification applies to our Business Associates who are obligated to notify our Practice if a breach of unsecured PHI occurs that affects you.

H) Fundraising: If PHI is used for fundraising which is considered "health care operations," basic requirements must be satisfied to include notice to you and a process for you to opt-out. If the individual consents, only specific parts of PHI may be used for fundraising. Note: Your PHI will not be used in this manner.

3. COMPLAINTS. You have the right to file a complaint if you believe your privacy rights or that of another individuals' have been violated. You may contact our Privacy Officer and your issue will be addressed. You may also file a complaint with the Secretary of Health and Human Services at: U.S. Department of Health & Human Services, Office of Civil Rights, 200 Independence Avenue, SW, Washington, D.C. 20201. Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail; name the covered entity or business associate involved and describe the acts or omissions you believe violated the requirements of the Privacy, Security, or Breach Notification Rules; and be filed within 180 days of when you knew that the act occurred. Visit the Office of Civil Rights website at www.hhs.gov/ocr/hipaa/ for more information.

If you have any questions, would like additional information or want to report a problem regarding the handling of your PHI, you may contact the Privacy Officer at:

Forever Smiles Family Dental
4528 W 26th Ave, Suite 110
Kennewick, WA 99338
509-591-4267
contact@foreversmileswa.com

You will not be penalized for filing a complaint.

FOREVER SMILES FAMILY DENTAL FINANCIAL POLICY

Assignment and Release
I the undersigned, have insurance with _____, and assign directly Forever Smiles Family Dental all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Patient Agreement and Financial Policy
I hereby agree to be responsible for the costs of care provided by Forever Smiles Family Dental and/or the dental team for myself or my dependent(s). These include any deductibles and amounts not covered by insurance. **I also understand that it is my responsibility to be aware of any limitations, and benefits of my insurance policy.** Payment to this office is my responsibility and I am aware that if the insurance company does not reimburse the doctor, I am responsible for the total amount(s).

I understand that there will be a $35 charge to all accounts in which a check payment is returned.

I understand that because appointments are not double-booked, I must provide notice of cancellation at least 2 business days prior to my scheduled appointment time. ***For appointments scheduled for 90 minutes or longer, I will be required to make a reservation fee of $100 prior to scheduling the appointment, which will be applied to my out-of-pocket expense for the appointment. This reservation fee is non-refundable. If I do not show up for my appointment or I do not give adequate notice if I am unable to keep my appointment, the reservation fee will be forfeited. For appointments scheduled for less than 90 minutes in length, a $85 cancellation fee may apply if I do not provide notice of cancellation at least 2 business days prior to my scheduled appointment time.***

We make every effort to schedule appointments that are most convenient for you and that fit your personal schedule. Because we do not schedule several patients at the same time, all appointments are reserved exclusively for you. In return, we ask that you make every effort not to change your reserved dental appointment.

I understand that for any treatment less than three hundred dollars ($300) payment in full is due at the time of service. I understand that after 60 days, any unpaid balance will incur a $10 billing fee. I understand that failure to pay amounts due to this office will result in my account being placed with a collection agency. In the event that my account is further referred to an attorney, I agree to pay all collection and attorney fees.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Minor/Child Consent
I, being the parent or legal guardian of _____, do here, by request and authorize the dental staff to perform necessary services for my child, including but not limited to radiographs (x-rays) and administration of anesthetics which are deemed advisable by the doctor, whether or not I am present at the actual appointment when the treatment is rendered. I also understand that the parent or guardian who brings my child in for treatment will be responsible for payment. A receipt will be provided so I may seek reimbursement.

Date: _____ Signature: _____
Signature of patient/parent/legal guardian

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Forever Smiles Family Dental. 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.

Forever Smiles Family Dental reserves the right to change the privacy practices that are 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 to me.

ADDITIONAL DISCLOSURE AUTHORITY 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 persons indicated below.				
ANY MEMBER OF MY IMMEDIATE FAMILY		YES		NO
SPOUSE ONLY		YES		NO
OTHER *(PLEASE SPECIFY)*		YES		NO

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not Obtained				
PROVIDER PRIOR TO TREATMENT?	YES NO		DATE STATEMENT PROVIDED: _____	
REASON FOR NOT OBTAINING SIGNATURE				NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES
				WANTED TO CONSULT WITH ANOTHER PERSON BEFORE SIGNING STATEMENT
				UNABLE TO SIGN
				REASON NOT GIVEN
			OTHER:	

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