

WELCOME

1

ABOUT YOU

Today's Date: ____ / ____ / ____ File #: _____

Patient Name: _____
LAST FIRST MI

What You Prefer To Be Called: _____ Male Female

Birthdate: ____ / ____ / ____ Age: ____ SS#: _____

Mailing Address: _____

CITY STATE ZIP

Home Phone #: (____) _____

Work Phone #: (____) _____ Ext: _____

Cell Phone #: (____) _____

E-mail Address: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

CITY STATE ZIP

Occupation: _____

Status: Minor Single Married Divorced Separated Widowed

Spouse's Name: _____

Do you have children? Yes No How many? _____

2

INSURANCE INFO

Primary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: (____) _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

Secondary Dental Insurance

Co. Name: _____

Address: _____

CITY STATE ZIP

Phone #: (____) _____

Insured's SS#: _____

Group # (Plan, Local, or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____ / ____ / ____

Insured's Employer: _____

4

IN EVENT OF EMERGENCY

Whom should we contact? _____

Relation: _____

Home Phone #: (____) _____

Work Phone #: (____) _____

Cell Phone #: (____) _____

Who is your Medical Doctor? _____

Medical Doctor's Phone #: (____) _____

3

ACCOUNT INFO

Person ultimately responsible for account

Name: _____

Relation: _____

Billing Address: _____

CITY STATE ZIP

SS #: _____

Drivers License #: _____

Work Phone #: (____) _____

Payment method: Cash Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

PLEASE CONTINUE ON BACK 

Reason for today's visit: Exam Emergency Consultation

Are you in pain? No Yes How Long? _____

Please indicate any of the following problems:

Discomfort, clicking or popping in jaw. Lost/Broken Filling(s) Stained teeth

Red, swollen or bleeding gums. Teeth grinding Locking Jaw

Sensitive tooth, teeth or gums. Ringing in Ears Bad breath

Blisters/Sores in or around the mouth. Broken/Chipped tooth

Other: _____

Do you require pre-medication? Yes No Don't know

Previous Dentist: _____ (____) _____
Name Phone#

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day you brush? _____ Times a week you floss? _____

What type of tooth brush bristles do you use? Soft Medium Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

MEDICAL HISTORY

Are you taking any of the following medications? Nerve pills Pain killers (including aspirin)

Muscle relaxers Stimulants Blood Thinners Tranquilizers Insulin

Other(s), please list: _____

Do you have or have you had any of the following diseases, medical conditions or procedures?

- | | | | |
|------------------------------------|------------------------------------|---------------------------------------|-------------------------------------|
| Y N Heart Attack / Stroke | Y N Thyroid Problems | Y N Cancer/Tumors | Y N Cosmetic Surgery |
| Y N Heart Surg./Pacemaker | Y N Kidney Problems | Y N Shingles | Y N Xray or Cobalt Treatment |
| Y N Heart Murmur | Y N Liver Problems | Y N Hepatitis | Y N Chemotherapy |
| Y N Rheumatic Fever | Y N Respiratory Problems | Y N HIV+/AIDS/ARC | Y N Asthma |
| Y N Mitral Valve Prolapse | Y N Sinus Problems | Y N Arthritis/ Rheumatism | Y N Difficulty Breathing |
| Y N Artificial Valves | Y N Stomach Problems/Ulcers | Y N Artificial Bones/Joints | Y N Diabetes/Hypoglycemia |
| Y N Heart Disease | Y N Psychiatric Problems | Y N Emphysema | Y N Leukemia |
| Y N Congenital Heart Defect | Y N Venereal Disease | Y N Fainting/Seizures/Epilepsy | Y N Anemia |
| Y N Chest Pains | Y N Alcohol/Drug Abuse | Y N Severe/Frequent Headaches | Y N High/Low Blood Pressure |
| Y N Scarlet Fever | Y N Tuberculosis TB | Y N Frequent Neck Pain | Y N Bleeding Problems |
| Y N Nervousness | Y N Jaw Problems TMJ/TMD | Y N Back Problems | Y N Glaucoma |

Please list any other surgeries or medical conditions you have or ever had: _____

Are you allergic to any of the following? Latex Penicillin / Amoxicillin Tetracycline Aspirin

Dental Anesthetics Others: _____

Do you use tobacco? No Yes/How used? _____ How much? _____ How long? _____

Please rate your general health from 1-10: _____ Do you wear contact lenses? Yes No

Have you ever taken the drug Phen-fen and or Redux? Yes No

For women: Are you taking Birth Control pills? Yes No How many children have you had? _____

Are you Pregnant? No Yes/How long? _____ Are you nursing? Yes No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature _____ Date ____ / ____ / ____

Adult Patient Parent or Guardian Spouse

UPDATE (OFFICE USE)

Initials _____ Date ____ / ____ / ____

Comments _____

Initials _____ Date ____ / ____ / ____

Comments _____

Initials _____ Date ____ / ____ / ____

Comments _____

STATEMENT OF PRIVACY PRACTICES

PITZEN FAMILY DENTISTRY

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principle concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality healthcare, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fundraising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

In no event will we use or disclose your Part 2 Program record or testimony that describes the information contained in your Part 2 Program record in any civil, criminally, administrative, or legislative proceedings by any Federal, State, or local authority unless authorized by your consent or the order of a court after it provides you notice of the court order.

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded and complete copy of our Statement of Privacy Practices is available for your review.

**ACKNOWLEDGEMENT
OF
PRIVACY PRACTICES
Pitzen Family Dentistry
Michael T. Pitzen DDS
4303 Bridgeport Way W
University Place, WA 98466
(253)564-5545**

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