Welcome

Thank you for choosing us for your dental care needs. We promise to do our best to provide you with the finest care available. If you have any questions, please do not hesitate to contact us. (206) 782-0600

PATIENT INFORMATION

Patient Name: _____ Social Security #: _____
(Last name) (First name) (Middle Initial)

Birth Date: _____ □ Male □ Female □Single □Married

Street Address _____ City _____ State _____ Zip _____

Home Phone: _____ Cell. Phone: _____ Email Address: _____

Confirmation preference : (circle all that apply) **cell text e-mail home work**

Employer: _____ Occupation: _____ Work Phone _____

DENTAL INSURANCE

Individual responsible for this account:

_____
(Last name) (First name) (Middle Initial)

Relationship to Patient: _____

Birth Date: _____ Soc. Sec #: _____

Street Address _____

City _____State _____ Zip _____

Home Phone: _____Work Phone: _____

Responsible Party Employed by: _____

Insurance Company _____

Subscriber I.D. #: _____ Group #: _____

ADDITIONAL INSURANCE

Insured Individuals Name:

_____
(Last name) (First name) (Middle Initial)

Relationship to Patient: _____

Birth Date: _____ Soc. Sec # _____

Street Address _____

City _____ State ____Zip_____

Home Phone: _____ Work Phone: _____

Insured Party Employed by: _____

Insurance Company _____

Subscriber I.D. #: _____Group #: _____

Whom may we thank for referring you to us? _____

IN CASE OF EMERGENCY CONTACT:

Name: _____ Relationship to You: _____

Home Phone: _____ Alt. Phone: _____

ASSIGNMENT AND RELEASE

I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other dental insurance" is indicated on other approved claim forms or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. **Payment is due in full at time of treatment unless prior arrangements have been approved.**

Signature: _____ **Date:** _____

Office Guidelines

We would like to welcome you to our practice and tell you how much we appreciate your choosing our practice for your oral health needs. In order for us to provide you with optimal service, we would like you to take a moment to read our office guidelines.

- If you have insurance, we will perform insurance estimates and bill the company as a courtesy. You will be responsible for your co-payments and your estimated patient portion at the time of service. If for any reason your insurance company denies any charges or does not cover the amount estimated, the responsibility for payment returns to you.

Payment for your treatment is expected on the day of service. We offer the following payment methods: cash, credit card (Visa, MasterCard, and American Express), check, or debit card. We offer assistance and accept payment plans through Capital One financing and Care Credit, which approves health care loans at no interest or low interest. **INITIAL REQUIRED _____**

If for any reason we over-collect on your patient portion, amounts under $200 will be kept on file for future dental treatment unless otherwise requested and we will advise you of the credit on your account at your next dental visit. If an amount over $200 is over-collected, we will contact you by phone.

A service charge of 1% per month is assessed for any balance remaining after 90 days from the service date.

- Minors, patients 18 years of age and under, must be accompanied by a parent or legal guardian at the time of treatment unless written treatment consent and pre-approved payment has been received.

- In the event that my account would need to be assigned to an outside collection agency, a 35% collection fee of the balance will be added to the account prior to the assignment.
  INITIAL REQUIRED _____

- Your appointment times are especially reserved for you. **In the event that you need to reschedule, please give us at least 2 business days of notice.** Please remember that failure to notify us 48 hours in advance will result in a **cancellation fee** of $50.00 per hour appointed. We reserve the right to terminate patients who miss scheduled appointments repeatedly. **INITIAL REQUIRED _____**

Consent for care

I grant permission to the doctor and staff to perform treatment as may be professionally deemed necessary or advisable, including x-rays, study models and photographs that may be needed for diagnostic aids. I agree to the use of anesthetics, sedatives, and other medication as necessary, and understand that using anesthetic agents embodies certain risks, and can ask for a complete recital of any possible complications.

I have read the office guidelines and consent for care. I understand and agree to these guidelines and consent.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Signature of Witness Date

STATEMENT OF PRIVACY PRACTICES

Jennifer Pichler, DDS
9720 Holman Road,
Seattle, Washington
206-782-0600

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal 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 to anyone – even family members – without your written consent. 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 of 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 Health Information

We will only request personal information needed to provide our standard of quality health care, 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 Health 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 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.

Patient Rights

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.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Jennifer Pichler, DDS

Jennifer Pichler, DDS
9720 Holman Road,
Seattle, Washington 98117
206-782-0600

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 Jennifer Pichler, DDS. 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.

Jennifer Pichler, DDS 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 health care 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		
PROVIDED PRIOR TO TREATMENT?	☐ **YES** ☐ **NO**	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):

DENTAL HISTORY

Patient Name: _____

Welcome! So that we may provide you with the best possible care please complete this dental history form. All information is completely confidential.

What is the reason for your visit today? _____

Date of last dental visit _____ Last dental cleaning_____

What was done at your last dental visit? _____

Last full mouth x-rays or pano _____

Previous dentist's name: _____

Address _____State _____ Zip _____

Telephone _____

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

What other dental aids do you use? (interplak, toothpick, etc.)_____

Do you have any dental problems now? Yes No

If yes, please describe:_____

Do you have a favorite side to chew on? Yes No If yes, which side? _____

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 tastes?	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?	Yes	No
or tooth loss?	Yes	No
Have you noticed any loose teeth or change in your bite?	Yes	No
If yes, where?_____ Pain?	Yes	No

Do you:

Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lips or cheeks regularly?	Yes	No
Mouth breath while awake or asleep?	Yes	No
Have tired jaws, especially in the morning?	Yes	No

Have you ever had:

Orthodontic treatment?	Yes	No
Oral Surgery?	Yes	No
Periodontal treatment?	Yes	No
Your teeth ground or the bite adjusted?	Yes	No
A bite plate or mouth guard ?	Yes	No
A serious injury to the mouth or head?	Yes	No
If so, please describe, including cause _____		

Have you experienced:

Clicking or popping of the jaw? (joint, ear, side of face)	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 have sleep apnea?	Yes	No

Satisfaction of Esthetics:

Do you like your smile? Yes No

If no, what don't you like? _____

_____

_____

Have you ever had an upsetting dental experience or do you feel nervous about dental treatment? Yes No

If so, please explain: _____

Is there anything else about having dental treatment that you would like us to know?_____

_____

Health Questionnaire

All answers will be held in strict confidence. Personal information and medical records will not be released to anyone with out your written authorization.

Name (please print)_____ Birthdate _____

Physician's Name _____ Physician's phone _____

Medical History **Yes** **No**

1. Have you ever experienced shortness of breath or chest pain?
2. Have you been a patient in a hospital in the last two years?
3. Have you experienced anemia, blood disorders or taken any blood thinners?
4. Have you been under a physician's care during the past two years?
5. Are you taking any medicines or drugs?
   If yes, please indicate which ones:

_____

_____

Yes **No**

6. Are you allergic or have you reacted adversely to any medicine or drug?

If yes, please indicate your allergy: _____

7. Do you smoke or chew tobacco?

8. Women: Are you pregnant or might be pregnant Yes No Due date: _____
   Are you nursing? Yes No

9. Check any of the following which you may have had:

Heart Disease	Glaucoma	Arthritis/Rheumatism
Heart Murmur	Diabetes	Sinus Trouble
Heart Surgery	Hepatitis: Type? A/B/C	Tuberculosis
Rheumatic Fever	Herpes	Asthma
Joint Replacement, Pins	Cold Sores/Fever Blisters	Latex Allergy
Cardiac Pacemaker	Kidney Disease	Skin Rash, Hives
Heart Valve Prosthesis	Persistent Cough	Epilepsy, Convulsions, Fainting
High or Low Blood Pressure	Ulcers	Seizures
HIV Positive	Tumor or Abnormal Growth	Alcoholism, Drug Addiction
Acquired Immune Deficiency Syndrome (AIDS)	Radiation/chemotherapy	Thyroid or Parathyroid Disease
AIDS Related Complex (ARC)	Cancer- When? What Kind?	Jaundice, Liver Disease
Stroke	Emotional Problems or Psychiatric Care	Blood Transfusion

10. Describe any other medical conditions we should know about:_____

_____

Patient /Parent or Legal Guardian Signature:_____Date: _____

Comments: _____

Health History Reviewed:

Date:				

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