SIGNATURE SMILES
Cristin Dowd DDS • Ken Wu DDS

13303 North East 175th St; Woodinville, WA 98072

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address:_____

Telephone:_____

SECTION B: 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 privacy 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 copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Christine Cutrer

Telephone: 425-489-1177 Fax: 425-489-3066

e-mail: signaturesmiles@yahoo.com

Address: 13303 North East 175th St; Woodinville, WA 98072
Right to Revoke: You will 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 in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

I, _____, 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.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.
REVOCATION OF CONSENT
I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.
I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

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Patient Name: _____ Date: _____
Last First MI

Social Security #_____ Birth Date:_____ Male/Female: _____

Address:_____
Street Apartment#

_____
City State Zip Code

Phone#_____ Work#_____ Cell#_____

Email Address:_____

Emergency Contact Name: _____ Relationship: _____ Number: _____

Have you had any of the following? Please check those that apply and explain.

- □ Aids/HIV
- □ Allergies to:
- □ Penicillin _____
- □ Codeine_____
- □ Latex _____
- □ Sulfa _____
- □ Other:_____
- □ Anemia
- □ Arthritis
- □ Artificial Joints
- □ Asthma mild/severe
- □ Blood Disease
- □ Bleeding disorder
- □ Cancer
- □ Diabetes
- □ Dizziness
- □ Epilepsy
- □ Fainting
- □ Glaucoma
- □ Growth/Tumors
- □ Hay fever
- □ Head Injuries
- □ Heart Disease
- □ Heart Murmur
- □ Hepatitis
- □ High Blood pressure
- □ Jaundice
- □ Kidney disease
- □ Liver disease
- □ Mental Illness
- □ Nervous tension
- □ Pacemaker
- □ Pregnancy (current): Due_____
- □ Radiation treatment
- □ Respiratory problems
- □ Rheumatic Fever
- □ Sinus problem
- □ Stomach problems
- □ Stroke
- □ Tuberculosis
- □ Ulcers
- □ Venereal disease

Explain in more detail: _____

_____

Family History of Diseases: (List) _____

_____

Social History: (frequency per week) (frequency per week)
Tobacco usage: Smoke/Dip _____ Alcohol usage: _____

Surgical History: _____

Medications: (including vitamins) **for what condition:** **dosage + frequency:**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Pre medication needed and for what condition: _____

Other Drug allergies: _____

Doctor's notes:_____

_____

Whom may we thank for referring you to our practice? □ Mailer □ Dental Office □ Yellow pages
□Google □Website □ Another Patient:_____Other:_____

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MEDICAL HEALTH FORM

Patient Name: _____ Date: _____
Last First MI

Please explain in detail if yes is checked:

1. Have you ever had any complications following dental treatment? □ Yes □ No

   _____

   _____

2. Have you been admitted to a hospital or needed emergency care during the past 5 years? □ Yes □ No

   _____

   _____

3. Are you under the care of a Physician? □ Yes □ No
   Conditions currently monitored: _____

   _____

   Name of Physician: _____ Phone: _____

   Name of Primary care Physician: _____ Phone: _____

4. Do you have any health problems that need further clarification? □ Yes □ No

   _____

   _____

To the best of my knowledge, all of the answers and information provided are true and correct. If I ever have any change in my health status, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent, or guardian

Doctor's notes:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

OVER →

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DENTAL HEALTH FORM

Patient Name: _____ Date: _____
Last First MI

DENTAL CONCERNS QUESTIONNAIRE

1. What is your primary dental or smile concern? _____
_____
2. When was the last time you were able to have your teeth cleaned? _____
3. What are your dental health goals? (get out of pain, improve oral health, better smile, prevention)
_____

PLEASE EXPLAIN IF YES IS CHECKED

4. Do you have any trouble chewing or speaking because of your teeth? □ Yes □ No
_____
5. Are any of your teeth or gums painful? □ Yes □ No
_____
6. Are you aware of grinding your teeth? □ Yes □ No Clenching? □ Yes □ No
_____
7. Do you have any problems or concerns with your jaws, gums, or teeth? □ Yes □ No
_____
8. Are you apprehensive about receiving dental care? □ Yes □ No
_____
9. Have you had problems with previous dental treatment? □ Yes □ No
_____
10. Have you ever had an adverse reaction to any medications while receiving dental care? □ Yes □ No
_____
11. How many times do you brush/day:_____ Floss/day: _____ Mouth rinse/day: _____
12. Ever had periodontal/gum treatment such as a deep cleaning? _____ When? _____
13. How can we make your visit more comfortable or enjoyable? _____

Doctor's notes:

_____
_____
_____
_____
_____
_____
_____

Insurance Information

Primary Insurance Plan Name _____ Phone #: _____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #:_____

Insured's Employer Name: _____Phone #:_____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Secondary Insurance Plan Name: _____Phone #:_____

Name of Insured: _____ Is insured a patient? ☐ Yes ☐ No
Last First MI

Insured's Birth Date: _____ SS #: _____ Group #:_____

Insured's Employer Name: _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other_____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1% per month (12% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of three months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

_____ Date: _____ Relationship to Patient:_____
Signature of patient, parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party

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Our Office Policies

Our office is committed to providing you with the finest quality dental care. In order to achieve this goal, we need your cooperation and your understanding of our appointment and payment policies.

Appointment Policy

Your appointment time is reserved especially for you. We respect your business schedule and make every effort to see you at your scheduled time. Please help us achieve this goal by being punctual for your appointment. In the event you are unable to keep your appointment, we respectfully request a minimum of 48 hours notice. This will give us adequate time to contact other patients who may find your reservation time more accommodating for them.

A missed appointment fee of $75.00 may be charged.

Thank you in advance for your cooperation.

Financial Policy

For our patients with no dental insurance:

If you are not insured, payment for services rendered is expected the day of the appointment. We accept cash, personal checks, VISA and MasterCard.

For our patients with dental insurance:

Please provide us with as much information about your plan(s) as you can, prior to your first appointment. This will allow us to verify your coverage, determine your benefits and give you an estimate of your expected portion before we pursue any treatment. As a courtesy to you, we will gladly submit your insurance claim on your behalf. However, **we expect and appreciate payment of your estimated co-pay at the time of each visit. We accept cash, personal checks, VISA, MasterCard, and CareCredit.**

Please be advised that your dental insurance is a contract between you and your insurance company and that patient charges are a contract between you and our office. Therefore, you are ultimately responsible for any balance on your account.

Authorization and release

Please be advised that the person signing this form is ultimately responsible for all account transactions and balances. Interest will accrue at the rate of 12% per annum on all outstanding balances.

If insurance is involved: I authorize payment directly to Cristin Dowd, DDS / Ken Wu, DDS of group benefits otherwise payable to me. I authorize all credit inquires deemed necessary in connection with my account.

Thank you for taking the time to completely read and sign this form.

Your name:_____

Signature:_____Date:_____