



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.

REVOCAION 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: _____

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.

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

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: _____

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.

Signature of patient, parent, or guardian

Date: _____

Doctor's notes:

Child Dental History

Date: _____

1. Is this your child's first visit to a dentist? _____ If NO, please give us the name and phone number of your child's previous dentist _____
Date of last dental visit _____ Any x-rays taken at that time? _____
(Please bring with you a copy of any x-rays taken at that time to avoid unnecessary repeats)
2. What do you believe to be your child's dental needs? _____
3. How do you think your child will respond to this visit? _____
4. Has your child ever had any negative experiences with physicians or other dentists? _____

5. Has your child ever suffered an injury to his teeth, jaws or face? If so, please give us more details:

6. Does your child suck any of his/her fingers or a pacifier? _____
7. Has your child ever taken or does your child currently take a bottle to bed at night? _____

8. Does your child take any form of supplemental fluoride at this time? _____
9. What conversation topics does your child currently enjoy? (i.e. animals, sports, cartoons, science)

Suggestions for gaining your child's trust and co operation during their 1st dental visit:

1. ***In general, if your child is under 3 years of age we encourage you to remain with your child in the operatory at all times. Children of this young age do better with strangers when their parents are close by.***
2. ***Parents of older children have the options of accompanying their child in the operatory or of remaining in the waiting area. However, our experience has taught us the following:***
 - *Children who are comfortable with strangers and who are relatively independent do well whether their parents are in the operatory with them or not.***
 - *Children who are wary of strangers, may be worried about the dental appointment, or are by nature more "clingy" to their parents, usually will not listen to a stranger (in this case, the dentist or dental assistants) when their parent is present. We encourage parents of apprehensive children to remain in the waiting area so that the dentist and other staff have a chance to gain the trust and establish a bond with the more difficult child.***
 - *We understand and respect the fact that some parents of apprehensive children do not wish to separate from their children during their dental appointments. We do allow these parents to accompany their child in the operatory during treatment.***

However, when a parent chooses to be in the operatory against our recommendation to remain in the waiting area, the parent is solely responsible for their child's behavior/co operation in the dental chair.

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.

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

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



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 Care Credit.

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: _____