NEW PATIENT INFORMATION FORM

Orchard Hills DENTISTRY

4804 Summitview Ave Yakima, WA 98908 | orchardhillsdentistry.com | (509) 452-6761

Mark if new: Address ☐ / Insurance ☐

Patient: _____

Address: _____

City: _____ Zip Code: _____

Birthdate: ____/____/____ Social Security # _____

Male ☐ Female ☐

Employer: _____

Occupation: _____

REFERRED TO THIS OFFICE BY: _____

☎ Home: _____ ☎ Work: _____

☎ Cell: _____ Best time to call: _____

Email: _____

Single ☐ Married ☐

Spouse's Name: _____

Spouse's Employer: _____

Spouse's Occupation: _____

DENTAL INSURANCE

Provider Name : _____

Subscriber's Name _____

Birthdate: ____/____/____ Social Security # _____

Employer: _____

Group #: _____

If you have additional dental coverage:

Provider Name : _____

Subscriber's Name _____

Birthdate: ____/____/____ Social Security # _____

Employer: _____

Group #: _____

Person responsible for the account: _____

DENTAL HISTORY

Do you have or do you use any of the following – indicate with (x):

- ☐ Sensitive to cold, heat, sweets or pressure
- ☐ Bleeding gums. How long?
- ☐ Food impaction
- ☐ Clenching or grinding
- ☐ Burning of tongue
- ☐ Swelling or lumps in mouth
- ☐ Frequent sores on lips or mouth
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Unfavorable dental experience
- ☐ Complications from extractions
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Mouth breathing
- ☐ Tobacco Use - Cigarette, cigar, chewing
- ☐ Take more than one alcoholic drink per day
- ☐ Fluoride supplements, rinses
- ☐ TMJ treatment (jaw joint)
- ☐ Fingernail biting, cheek biting, etc
- ☐ Consent for Nitrous Oxide sedation
- ☐ Pain around ear or jaw

How do you feel about your smile?

Would you like your teeth whiter? Yes ☐ No ☐

Are you concerned with stains on your teeth? Yes ☐ No ☐

Do you think your teeth are too crooked? Yes ☐ No ☐

Do you have missing teeth that you would like replaced? Yes ☐ No ☐

I would like more information about: _____

_____

CONSENT

1. The undersigned hereby authorizes the doctor to take x-rays, study models. photographs. or any diagnostic aid deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)_____ I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. I understand that where appropriate permission is given for the doctor and staff to send necessary models, x-ray and health related information to appropriate dental specialists or insurance carriers. This permission will remain in force as long as I am a patient of this dental practice. I also authorize release of photographs or other images for educational publication or presentation.
4. I understand that all responsibility for payment for dental service provided in this office for myself or my dependents is mine, due and payable at the time of services are rendered, unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1.5% finance charge (18% APR) may be added to my account in addition to any collection charges.
5. I understand that where appropriate, credit bureau reports may be obtained.
6. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

Patient: _____ Date: _____ Witness: _____

Parent or Responsible Party: _____ Relationship to Patient: _____

Emergency Contact Person: _____ Phone: _____

FOR OFFICE USE:

Reviewed by Dr _____ Date: _____

Orchard Hills DENTISTRY

HEALTH HISTORY

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Patient: _____ Birthdate: ____/____/____

1. Do you have any current health problems? . . . . . Yes ☐ No ☐ If "Yes," please note in the "Health Problems" section
2. Are you under a physician's care now? . . . . . Yes ☐ No ☐ If "Yes," what? _____
3. Are you currently taking any medication* . . . . . Yes ☐ No ☐ If "Yes," what? _____

(*including prescription, herbal, and over-the-counter medications) _____

ALLERGIES & ADVERSE REACTIONS

CHECK THE FOLLOWING FOR WHICH YOU ARE ALLERGIC OR HAVE HAD ADVERSE REACTIONS:

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Local Anesthetics
☐ Tylenol ☐ Erythromycin ☐ Nitrous Oxide ☐ Metals
☐ Ibuprofen ☐ Sulfa ☐ Latex, Rubber Dam ☐ Other (Please describe) _____

HEALTH PROBLEMS

CHECK ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR PRESENTLY HAVE:

☐ Heart Problems	☐ Ulcers/Colitis	☐ Hay Fever	☐ Shortness of Breath	☐ Hepatitis/Liver Problems	☐ Sinus Problems
☐ Chest Pain	☐ Drug Dependency	☐ Skin Rashes	☐ High Blood Pressure	☐ Alcoholism	☐ Asthma
☐ Heart Murmur	☐ Psychiatric Treatment	☐ Osteoporosis	☐ Rheumatic Fever	☐ Eating Disorders	☐ Arthritis
☐ Heart Valve	☐ Diabetes	☐ Artificial Joints	☐ Artificial Heart Valve	☐ Epilepsy/Seizures/Fainting	☐ Cortisone
☐ Pacemaker	☐ Emphysema	☐ Pain in Jaw Joints	☐ Heart Surgery	☐ Glaucoma	☐ Tobacco Use
☐ Hemophilia	☐ Cancer Treatment	☐ Fen-Phen	☐ Anemia	☐ Kidney Problems	☐ HIV-positive/AIDS
☐ Bruise Easily	☐ Thyroid Disease	☐ Autoimmune Disease	☐ Abnormal Bleeding	☐ Tuberculosis (TB)	☐ Stroke
☐ Considering Pregnancy					

Premed Rx: _____

Pharmacy: _____

Primary Physician: _____

Patient/Parent Signature: _____ Date:_____

Dentist Initial: _____

UPDATES

Date: _____ Initials: _____ Changes to above: _____
Date: _____ Initials: _____ Changes to above: _____
Date: _____ Initials: _____ Changes to above: _____
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Orchard Hills DENTISTRY

FINANCIAL POLICY FORM

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Our provision of care to you will result in a bill for our services. Following is a statement of our financial policy, which we request you read and sign prior to your treatment. In addition all patients must provide basic registration and insurance information before seeing the Doctor.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE, UNLESS WE ARE BILLING YOUR INSURANCE FOR YOU, IN WHICH CASE, ANY APPLICABLE CO-PAYMENT OR DEDUCTIBLE IS DUE AT TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA/MC OR CARE CREDIT.

REGARDING INSURANCE

We ask that you show us a copy of your dental insurance card at the time of each visit so we can set up the correct billing information. As a courtesy we will bill your insurance carrier for the charges which the company has agreed to pay. You are responsible for any amounts not covered by your insurance, including co-payments and deductibles. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If you do not inform us of any special requirements or guidelines in your policy, such as second opinions, pre-authorizations, preferred providers and covered and non-covered services, and we subsequently perform or order items or services that are not covered we will have to bill you directly for those charges, If your insurance company has not paid your account within 45 days, the account automatically becomes your responsibility and will become due immediately. Please be aware that some of the items or services provided may not be covered or may not be approved for payment under your policy, but have been deemed to be in your best interest by your Doctor.

RESPONSIBILITY

If you are 18 or older, you are legally responsible for your own account, regardless of who you come with, who has a contract with an insurance company or who claims you as a tax deduction. If the patient is under 18, both parents, despite divorce or other separating arrangements, or the legal guardian of the patient, are responsible for payment.

I have read the Financial Policy and understand and agree to its terms.

_____ Date: _____

Signature of patient or responsible party

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 CAREFULLY.

The Health Insurance Portablility & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form whether electronically , on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purpose of treatment, payment, and health care operations.

- **Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.**
- **Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.**
- **Health Care Operations include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.**

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment of your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards, and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses or disclosures will be made only with your written authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the address listed below:

- **The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction to a restriction, we must abide by it unless you agree in writing to remove it.**
- **The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.**
- **The right to access, inspect and copy your protected health information with limited exceptions. A reasonable fee may be assessed.**
- **The right to request an amendment to your protected health information. We may deny your request in certain situations.**
- **The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations… or based on your previous authorization.**
- **The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.**

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective dates and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Orchard Hills Dentistry
4804 Summitview Avenue
Yakima, WA 98908
(509)452-6768

For more information about HIPAA or to file a Complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877)696-6775 (toll free)

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Acknowledgement of Privacy Practices

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 1196 (HIPPAA). 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: _____

Additional Disclosures Authority:

OTHER _____ your signature

OTHER _____ their name/your signature

Other-specify _____ name/your signature

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

Orchard Hills DENTISTRY

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E-Mail: info@orchardhillsdentistry.com

REQUEST FOR RECORDS

DATE: _____

Dear Dr. _____

_____ DOB: _____ has requested that you review your records and radiographs and forward them to our office. Please provide the following:

BWX _____

FMX _____

PANO _____

Periodontal Charting _____

Last exam & Prophy, Periomaintenance and/or SRP's _____

Patient Name (print) _____ Date of Birth _____

Patient Signature _____

Signature of Guardian / Authorized Representative _____

Relationship to Patient _____

If you have any questions, please do not hesitate to call our office.

Thank you,

Dr. Stephen Connell
Dr. Mark Young
And Team