WALLA WALLA DENTAL CARE

WELCOME TO OUR OFFICE!

FIRST NAME: _____ LAST NAME:_____ MI:_____

ADDRESS:_____

CITY, STATE, ZIP: _____

BIRTH DATE: _____ SOCIAL SECURITY: _____

EMAIL: _____

HOME PHONE: _____ CELL PHONE: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? _____

EMERGENCY CONTACT NAME: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

PRIMARY INSURANCE INFORMATION

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER ID:_____

SUBSCRIBERS' EMPLOYER:_____ GROUP NUMBER:_____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE COMPANY NUMBER:_____

SECONDARY INSURANCE INFORMATION

SUBSCRIBER NAME: _____

SUBSCRIBER DATE OF BIRTH: _____ SUBSCRIBER ID:_____

SUBSCRIBERS' EMPLOYER:_____ GROUP NUMBER:_____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

INSURANCE COMPANY NUMBER:_____

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Walla Walla Dental Care all insurance benefits, if any, otherwise payable to me for any services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance.** I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

_____ _____

Responsible Party Signature Date Signed

_____ _____

Parent/Legal Guardian's signature Date Signed

MEDICAL HISTORY

PATIENT NAME: _____ NICKNAME:_____ AGE:_____

NAME OF PHYSICIAN AND THEIR SPECIALTY:_____

MOST RECENT PHYSICAL EXAM:_____PURPOSE: _____

What is your estimate of your general health: ☐ EXCELLENT ☐ GOOD ☐FAIR ☐POOR

DO YOU HAVE OR HAVE YOU EVER HAD:	YES	NO
1. Hospitalization for illness or injury_____	☐	☐
2. An allergic reaction to -		
☐ Aspirin		
☐ Penicillin		
☐ Erythromycin		
☐ Tetracycline		
☐ Sulfa		
☐ Local Anesthetic		
☐ Fluoride		
☐ Metals (Nickel, Gold, Silver, _____)		
☐ Latex		
☐ Other _____		
3. Heart problems, or cardiac stent within the last 6 months_____	☐	☐
4. History of ineffective endocarditis_____	☐	☐
5. Artificial heart valve, repaired heart defect (PFO)_____	☐	☐
6. Pacemaker or implant defibrillator_____	☐	☐
7. Artificial prostesis (heart valve or joints)_____	☐	☐
8. Rheumatic or scarlet fever_____	☐	☐
9. High or low blood pressure_____	☐	☐
10. A stroke (taking blood thinners)_____	☐	☐
11. Anemia or other blood disorder_____	☐	☐
12. Prolonged bleeding due to a slight cut (INR>3.5)_____	☐	☐
13. Emphysema, sarcoidosis_____	☐	☐
14. Tuberculosis_____	☐	☐
15. Asthma_____	☐	☐
16. Breathing or sleeping problems (i.e. snoring, sinus)___	☐	☐
17. Kidney Disease_____	☐	☐
18. Liver disease_____	☐	☐
19. Jaundice_____	☐	☐
20. Thyroid, parathyroid disease, or calcium deficiency__	☐	☐
21. Hormone deficiency_____	☐	☐
22. High cholesterol or taking a statin drug_____	☐	☐
23. diabetes (HbA1c=_____) _____	☐	☐
24. Stomach or duodenal ulcer_____	☐	☐
25. Digestive disorder (i.e. gastric reflux)_____	☐	☐

	YES	NO
26. Osteoporosis/osteopenia (i.e. taking bisphosphonates)_____	☐	☐
27. Arthritis_____	☐	☐
28. Glaucoma_____	☐	☐
29. Contact Lenses_____	☐	☐
30. Head or neck injuries_____	☐	☐
31. Epilepsy, convulsions (seizures)_____	☐	☐
32. Neurological problems (attention deficit disorder)___	☐	☐
33. Viral infections and cold sores_____	☐	☐
34. Any lumps or swelling in the mouth_____	☐	☐
35. Hives, skin rash, hay fever_____	☐	☐
36. STI/STD_____	☐	☐
37. Hepatitis (type_____)_____	☐	☐
38. HIV/AIDS_____	☐	☐
39. Tumor, abdominal growth_____	☐	☐
40. Radiation therapy_____	☐	☐
41. Chemotherapy_____	☐	☐
42. Emotional problems_____	☐	☐
43. Psychiatric treatment_____	☐	☐
44. Antidepressant medication_____	☐	☐
45.. Alcohol/street drug use_____	☐	☐
ARE YOU:		
46. Presently being treated for any other illness_____	☐	☐
47. Aware of changes in your health (i.e fever; cough)____	☐	☐
48. Taking medication for weight management (i.e fen-phen)_____	☐	☐
49. Taking dietary supplements_____	☐	☐
50. Often exhausted or fatigued_____	☐	☐
51 Experiencing frequent headaches_____	☐	☐
52. A smoker; smoked previously or use smokeless tobacco_____	☐	☐
53. Considered a touchy person_____	☐	☐
54. Often unhappy or depressed_____	☐	☐
FEMALES:		
55. Taking birth control pills_____	☐	☐
56. Pregnant_____	☐	☐
MALES:		
57. Prostate disorders_____	☐	☐

ASK FOR AN ADDITIONAL SHEET IF YOU ARE TAKING MORE THAN SIX MEDICATIONS

PLEASE ADVISE US IF THERE ARE CHANGES IN YOUR MEDICAL HISTORY OR MEDICATIONS LIST YOU MAY BE TAKING

DRUG	PURPOSE	DRUG	PURPOSE

DESCRIBE ANY CURRENT MEDICAL TREATMENT, IMPENDING SURGERY, GENETIC/DEVELOPMENT DELAY, OR OTHER TREATMENT THAT MAY POSSIBLY AFFECT YOUR DENTAL TREATMENT (i.e. BOTOX, COLLAGEN INJECTIONS)

LIST ALL MEDICATIONS, SUPPLEMENTS, AND OR VITAMINS TAKEN WITHIN THE LAST TWO YEARS

_____

PATIENT'S SIGNATURE DATE SIGNED

_____

DOCTOR'S SIGNATURE DATE SIGNED

HIPAA RELEASE OF MEDICAL INFORMATION

walla walla DENTAL CARE "Partners in Excellence"

HIPAA, stands for the Health Insurance Portability and Accountability Act of 1996, which is United States legislation that sets data privacy and security provisions for safeguarding medical information, such as medical records and other identifiable health information. By signing below you are authorizing us to disclose your medical information.

I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

Spouse only: _____

Any member of my immediate family

Family member name:_____

Relationship:_____

Family member name:_____

Relationship:_____

Other (please specify):

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

Patient, Parents, or legal guardian — DATE SIGNED

_____ _____

Printed name if signed on behalf of the patient — Relationship (parent, legal, guardian, etc.)

(OFFICE USE ONLY)

PROVIDED PRIOR TO TREATMENT ___Yes ___No

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):_____

FINANCIAL AGREEMENT

You are directly responsible for payment of treatment. As a courtesy, we accept assignment of benefit payments from your insurance company. This will reduce your immediate out-of-pocket expenditures. We will do our utmost to help you derive the maximum benefits to which you are entitled.

The insurance estimates we give you are based on limited information obtained from your insurance company. If we need more detailed information on your benefits in order to file your claim, YOU will need to provide that to us.

Insurance companies calculate their payment on the contract signed with your employer, not the doctor's fees.

This office will not file an insurance claim which falsifies dates of treatment, fees charged, treatment performed, or any other information.

Our goal is to provide quality dental care in a timely manner. The following policy is with regard to patients who fail to keep their reserved office visit.

Our no show and late cancellation policy enables us to better utilize available appointment times for our patients in need of dental care.

Please be courteous and call us promptly if you are unable to attend an appointment.

A failure to be present at the time of a scheduled appointment will be recorded in your dental record as a "no-show." Failure to cancel without 24 hour notice will result in a $50 fee. The fee is not covered by insurance and is therefore the sole responsibility of the patient.

No further appointments will be scheduled until this cancellation fee has been reconciled.

No Show Policy/Late Cancellation Policy

First failed appointment: courtesy reschedule
Second failed appointment: $50 fee will be billed to your account
Third failed appointment: $50 fee will be billed to your account and you may be discharged from our practice

Thank you for the opportunity to help you meet your oral health goals and taking the time to read and understand our financial options. Please feel free to ask any questions you may have. We look forward to providing you with the highest level of professional care.

_____ _____

Patient signature of acknowledgement DATE SIGNED

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

We keep record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more infomation about it by contacting our Office Manager.

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have reveiced a copy of the STATEMENT OF PRIVACY PRACTICES for Walla Walla Dental Care, the office of Dr. Danis Laizure, DMD. The STATEMENT OF PRIVACY PRACTICES describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of services, or in the performance of office health care operations. The STATEMENT OF PRIVACY PRACTICES also describes my rights and responsibilities and duties in this office with respect to my protected health information.

Walla Walla Dental Care reserves the right to change the privacy practices that are descrived in the STATEMENT OF PRIVACY PRACTICES. If the 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 disclosure describes in the STATEMENT OF PRIVACY PRACTICES

By my signature below I acknowledge receipt of the Notice of Privacy Practices

_____ _____

Patient or legally authorized signature | DATE SIGNED

_____ _____

Printed name if signed on behalf of the patient | Relationship (i.e. Parent/Legal Guardian)