New Patient Information and Health History

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important for your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ Gender: _____ Pronouns: _____

Preferred name: _____ Date of birth: _____ Age: _____

Home address: _____
Street City State Zip

Billing address: _____
(if different) Street City State Zip

Home phone: _____ Cell: _____

E-mail: _____

SS #: _____ Employer/Occupation: _____

Emergency Contact: _____ Phone Number: _____ Relation: _____

How did you hear about North Creek Dental Care? _____

Insurance Information:

Primary dental insurance: _____ Policy Holder: _____

Date of Birth: _____ Subscriber ID: _____ Relation: _____

Secondary dental insurance: _____ Policy Holder: _____

Date of Birth: _____ Subscriber ID: _____ Relation: _____

Medical Doctor: _____ Date of last visit to Medical Doctor: _____

Previous Dentist: _____ Date of last dental cleaning/exam: _____

Preferred Pharmacy: _____

Name: _____ DOB: _____

Dental History

Y / N Are you apprehensive about dental care?

Y / N Have you had problems with previous treatment?

Y / N Do you gag easily?

Y / N Do you wear dentures or partials?

Y / N Do your gums bleed easily? Feel swollen or tender?

Y / N Have you ever been told you have or are at risk of periodontal disease?

Y / N Have you noticed slow-healing sores in your mouth?

Y / N Are your teeth sensitive?

Y / N Does your mouth feel dry?

Y / N Are you dissatisfied with the appearance of your teeth?

Y / N Does your jaw make noise that bothers you or others?

Y / N ` Do you clench or grind your teeth frequently?

Y / N Do you have a temporomandibular (jaw) disorder?

Y / N Are you aware of an uncomfortable bite?

Y / N Have you had a blow to the jaw (trauma)?

Y / N Have you had orthodontics/braces?

Y / N Do you have wisdom teeth?

Medical History

Do you have, or have you had any of the following?

Heart Disease/Problems: _____
- History of heart attack? Y / N When: _____
- Chest pain? Y / N
- Blood pressure? Y / N High or low?_____
- Taking heart medication? Y / N
- Pacemaker? Y / N When: _____
- Endocarditis? Y / N
- Valve replacement? Y / N When: _____
- Mitral valve prolapse? Y / N When: _____
- Heart murmur? Y / N

Blood disease:_____
- HIV? Y/N
- AIDS? Y / N

Blood problems: _____
- Easy bruising? Y / N
- Excessive bleeding? Y / N

Cancer, tumor or radiation? Y / N
If yes, please explain: _____
_____
_____

Fainting spells, seizures, epilepsy? Y / N

Stroke? Y / N When: _____

Thyroid condition? Y / N
- Hypo or hyper?_____

Bone or joint problems? Y/ N
- Arthritis? Y / N
- Osteoporosis? Y / N
- Joint replacement? Y / N
- What joint / when? _____

History of head, neck or jaw injury? Y / N
- Back pain? Y / N
- Neck pain? Y / N
- Jaw pain? Y / N

Frequent or severe headaches? Y / N

Do you have or have you had tuberculosis? Y / N

Do you smoke/vape/chew? _____ If yes, how much?_____

Do you have sleep apnea or symptoms of sleep apnea?
Y / N CPAP? Yes / No

Hepatitis, jaundice or liver trouble? Y / N _____

Diabetes? Y / N If yes Type 1 or type 2?
- Thirsty or mouth is dry much of the time? Y / N
- Are you Insulin dependent? Y / N

Asthma/ respiratory problems? Y / N

Medical History continued-

Are you allergic to, or have you reacted adversely to latex or medications? Y / N
If yes, please explain: _____
_____
_____

Are you taking any of any of the following?

- ☐ Aspirin
- ☐Anticoagulants (blood thinners)
- ☐Antibiotics or sulfa drugs
- ☐ High blood pressure medicine
- ☐Insulin, Orinase or other diabetic medications?
  _____
  _____
- ☐ Antibiotics prior to dental appointments? _____
  _____
  _____

Have you ever taken Biphosphonate, Fosamax, Boniva, Actonel or Aredia? Y / N _____

Have you taken Suboxone or Buprenorphine? Y / N
_____

History of alcohol or drug abuse? Y / N _____
_____

Women:

- ☐ may be pregnant
  Expected delivery date:_____
- ☐ Nursing

Do you have any disease, condition or problem not listed above that you feel we should know about? _____
_____
_____

Current medications (including supplements): _____
_____
_____

Medications taken in the last 12 months: _____
_____

I have read the above questions and understand them. I will not hold my dentist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my dentist of any changes in my medical or dental health.

Signature of patient (or parent): _____ Date: _____

Doctor or hygienist signature: _____

Notice of Privacy Practices

North Creek Dental Care
Donald A. Koontz, DDS
Nicholas J. Conley, DDS
12806 3rd Ave. SE
Everett, WA 98208
(425) 338-0666

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION

OUR LEGAL DUTY

Federal and state law requires us to maintain the privacy of your health information. That law also requires us to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices we describe in this notice while in effect, as of April 14, 2003.

We reserve the right to make changes to our policies and the terms of this notice at any time. Prior to making any said changes, we will update the documentation available to you. You may request a copy of our policies, at any time. Once you have completed this reading, our office manager can address any additional questions you may have.

USES & DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. Such are, but are not limited to, the following:

Treatment: We may use your health information for treatment and disclose it to a dentist, physician, or other health care provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you. We may disclose your health information to another health care provider or entity that is subject to the federal Privacy Rules for its payment activities.

Health Care Operations: We may use and disclose your health information for our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation and certification, licensing or credentialing activities. We may disclose your health information to another health care provider or organization that is subject to the federal privacy rules and that has a relationship with you to support some of their health care operations. We may disclose your health information to help these organization conduct quality assessment, as well as detect or prevent health care fraud and abuse.

On Your Authorization: You may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing any time. Your revocation will not affect any use or disclosures permitted by your authorization while if was

in effect. Unless you give us your written authorization, we cannot use or disclose your information for any reason except those previously described in this notice.

To Your Family and Friends: We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your health care or with payment for your health care. Before we disclose your health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event of your incapacity or an emergency, we will disclose your medical information based on our professional judgment of whether the disclosure would be in your best interest. We may use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescription, dental x-rays, supplies or other similar forms of health information. We may use or disclose information about you to notify or assist in notifying a person involved in your care, of your location and general condition.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

Disaster Relief: We may use or disclose your health information to a public or private entity authorized by law or its charter to assist in disaster relief efforts.

Public Benefit: We may use your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- As required by law
- For public activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury
- To report adult abuse, neglect, or domestic violence
- In response to court and administrative orders and other lawful processes
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other persons
- To coroners, medical examiners, and funeral directors
- To avert a serious threat to health or safety
- In connection with certain research activities
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information and allow sufficient time for staff to provide said information. You may request access by sending a letter to the following address: 12806 3rd Ave N. Everett, WA 98208. If you request copies, we will charge you a reasonable cost-based

fee that may include labor, copying costs, and postage. You may contact us in regards to an estimate for fees potentially assessed.

Disclosure Accounting: You have the right to receive a list of instances in which we disclosed your health information over the last 6 years (but not prior to April 14, 2003). That list will not include disclosures for treatment, payment, health care operations, as authorized by you, and for certain other activities. If you request this accounting more than once in a 12-month period, we will charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have to request that we place additional restrictions on our use of your health information. We are not required to agree to these additional terms. If we do, we will abide by our exclusive agreement, with the exceptions of emergency. Any agreement we may make to a request for additional restrictions must be presented by you, the patient, in writing and signed by a person authorized to make such an agreement on our behalf. Your request is not binding unless our agreement is in writing.

Amendment: You have the right to request that we amend your health information. Your request must be in writing, and it must explain why we should amend the information. We may deny such request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you believe:

- We may have violated your privacy rights
- We made a decision about access to your health information incorrectly, or
- Our response to a request you made to amend or restrict the use of disclosure of your health information was incorrect

You may contact us via written response. You may also submit a written complaint to the US Department of Health and Human Services. We support your right to privacy and will not retaliate in any manner should you so choose to file a complaint with the US Department of Health and Human Services.

Acknowledgement of Privacy Practices

North Creek Dental Care
Donald A. Koontz, DDS
Nicholas J. Conley, DDS
12812 B 3rd Ave. SE
Everett, WA 98208
(425) 745-3766

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 1996 (HIPAA). I understand that this information can and will be used to:

• Provide and coordinate my treatment among multiple 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 and 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 acknowledgment: _____

_____

Additional Disclosure Authority:

Any member of my immediate family: Yes____ No____

Spouse only: Yes ____No____

Other: Yes____ No ____ Specify_____

Donald A. Koontz, DDS
12812 3rd Ave SE, Suite B Everett, WA 98208

Financial and Cancellation Policy

We are committed to providing you with the best possible care. Our fees reflect our professional commitment to excellence. If you have insurance, we're happy to help you receive your maximum allowable benefits. To achieve these goals, we need your assistance and your understanding of our financial policy.

Financial Policy: North Creek Dental Care is happy to partner with our patients who have dental insurance by billing the insurance for you. However, it is your responsibility to inform us when your policy changes so we can bill the correct carrier. We ask that you are familiar with your dental policy and your dental benefits, please call your insurance company if you have questions about your dental benefits. Please understand that our responsibility is to provide superior dental care and treatment that meets your dental needs.

Our front desk staff wants to assist you in obtaining the maximum benefits specified in your contract. It is important that you understand the following:

- Your insurance benefit is a contract between you and the insurance company, we are not party to that contract. We will file your claims as a courtesy to you.
- Not all recommended services are covered benefits by your insurance.
- You are responsible for all fees for services rendered to you, not your insurance company.
- Upon request a pre-determination of dental benefits can be provided to you.
- Estimated patient portions are due at the time of service. These estimates are based on the outline given by your insurance plan. There is no guarantee of payment from your insurance plan until the claim is processed.
- A finance charge of 18% APR will be applied to any account balance 90 days or older.

Cancellation Policy: When you schedule an appointment, we reserve a specific amount of time especially for you and we trust you to be responsible for remembering and keeping your appointment. As a courtesy, we will do our best to confirm your appointment with our first reminder 7 days prior to your scheduled appointment. Please be sure we have your correct phone number and email address. We understand that schedules change, and emergencies happen and ask for as much notice as possible. If you are unable to keep your scheduled appointment, we respectfully request a two-business day notice to cancel or change an appointment to avoid a broken/missed appointment fee of $50.00 fee for the first hour and $25.00 subsequent hour. Failed appointments or "No-Show" appointments will also result in a broken/missed appointment fee.

_____
Patient Signature

_____ _____
Patient Name Date