Cle Elum Dental Clinic

DANIEL K. WHITEMARSH, DMD

Last Name_____ First Name _____ MI _____

Male/Female Birthdate_____ SS# _____ Single/Married/Child

Mailing Address _____ City _____State ____ Zip _____

E-mail: _____ Home Phone_____

Cell Phone _____Work Phone _____ ext _____

Employer/School _____

Emergency Contact _____Phone#_____

Who may we thank for referring you? _____

PRIMARY DENTAL INSURANCE

Insurance Co. _____

Group # _____ ID# _____

Insurance Co. Address

_____

Phone # _____

Subscriber Name _____

D.O.B._____ Employer_____

SECONDARY DENTAL INSURANCE

Insurance Co. _____

Group # _____ ID# _____

Insurance Co. Address

_____

Phone # _____

Subscriber Name _____

D.O.B._____ Employer_____

Who is responsible for this account_____ relationship to patient_____

Address_____ Phone _____ D.O.B._____ SS#_____

I hereby authorize the above named insurance company to release payment directly to Cle Elum Dental Clinic. I understand that I am financially responsible whether or not paid by insurance.

Signed _____ Printed name _____Date _____

206 West 1st Street • Cle Elum, WA 98922

(509) 674-2307 • Fax (509) 674-7330

Cle Elum Dental Clinic
Financial Policy

Welcome to Cle Elum Dental Clinic! Our entire team is committed to providing you and your family with the quality care that you expect and deserve from a professional dental practice. We understand that you may have questions relating to our financial and insurance billing practices therefore, we encourage you to ask our staff questions at any time.

I. IF YOU ARE COVERED BY INSURANCE

Patients with insurance are expected to make a down payment (copays) at the time of service. This amount is based on an estimate of the portion not covered by your insurance. It is your responsibility to know the terms of your insurance coverage, as well as any exclusion, limitations, deductibles and copays.

II. IF YOU ARE NOT COVERED BY INSURANCE

If you do not have insurance, payment for services is expected at the time of treatment.

III. PAYMENT OPTIONS

Payments may be made with VISA, MasterCard, Discover Card, debit card, cash or personal check. We also offer payment plans through Care Credit, please ask for details. There will be a $35.00 fee on all returned checks unpaid by your bank. Account balances over 30 days past due will accrue a monthly $5 fee.

IV. CANCELLATION AND MISSED APPOINTMENTS

Your appointment is designed specifically for you. If you need to change or cancel your appointment, we require you do so within 48 hours of your scheduled appointment. **Appointment cancellations made less than 48 hours prior to your scheduled appointment and missed appointments are subject to a fee of $50.**

Note: Insurance is underwritten as a contract between the patient and the insurance company therefore; it is the patient who is responsible for the bill, regardless of an insurance coverage determination. We are happy to bill your primary or secondary insurance company for you as a courtesy. Please keep in mind that the responsibility for the payment remains with the patient.

AUTHORIZATION

With my signature below, I hereby authorize the release of any relevant information necessary to process a claim(s) to my insurance company. I also authorize any insurance benefits otherwise payable to me to be paid directly to Cle Elum Dental Clinic for providing services.

PLEASE SIGN AND RETURN TO THE RECEPTIONIST

I acknowledge that I am financially responsible for all charges. If it becomes necessary to use a collection agency for any amount owed on this or subsequent visits, the undersigned agrees to pay for all legal costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information necessary to secure payment.

Signature: _____

Date: _____

Medical History (continued)

Your current physical health is: Good Fair Poor

Are you currently under the care of a physician? Yes No

Please Explain:_____

Are you taking any prescription / over-the-counter drugs? Yes No

Please list each one:_____

Do you smoke or use tobacco in any other form? Yes No

For Women: Are you taking birth control pills? Yes No

Are you pregnant? Yes No Week #:_____

Are you nursing? Yes No

Have you ever had any of the following disease or medical problems? (Please circle option that applies)

Y N	Anemia / Radiation Treatment	Y N	Hemophilia / Abnormal Bleeding
Y N	Artificial Bones / Joints/ Valves	Y N	Hepatitis
Y N	Arthritis	Y N	High / Low Blood Pressure
Y N	Asthma	Y N	HIV+ / AIDS
Y N	Blood Transfusion	Y N	Hospitalized for Any Reason
Y N	Cancer / Chemotherapy	Y N	Kidney Problems
Y N	Congenital Heart Defect	Y N	Mitral Valve Prolapse
Y N	Diabetes	Y N	Psychiatric Problems
Y N	Difficulty Breathing	Y N	Rheumatic / Scarlet Fever
Y N	Drug / Alcohol Abuse	Y N	Severe / Frequent Headaches
Y N	Emphysema / Glaucoma	Y N	Shingles
Y N	Epilepsy /Seizures / Fainting Spells	Y N	Sickle Cell Disease / Traits
Y N	Fever Blisters / Herpes	Y N	Sinus Problems
Y N	Heart Attack / Stroke	Y N	Tuberculosis (TB)
Y N	Heart Murmur	Y N	Ulcers / Colitis
Y N	Heart Surgery / Pacemaker	Y N	Venereal Disease

Please list any serious medical condition(s) that you have ever had:

_____

Are you allergic to any of the following?

Y N	Aspirin	Y N	Erythromycin	Y N	Penicillin
Y N	Codeine	Y N	Jewelry / Metals	Y N	Tetracycline
Y N	Dental Anesthetics	Y N	Latex	Y N	Other

Please list any other drugs / material that you are allergic to :_____

_____

Dental History

Why have you come to the dentist today?

_____

_____

Do you require antibiotics before dental treatment? Yes No

Are you currently in pain? Yes No

Have you ever had a serious / difficult problem associated with any previous dental work? Yes No

Do you now or have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? Yes No

Your current dental health is: Good Fair Poor

Do you like your smile? Yes No

Do your gums ever bleed? Yes No

How many times a week do you floss?____ a day do you brush?____

Type of bristles? Hard Medium Soft

Have you ever taken Phen-Fen? Yes No
(also known as Redux or Pondimin)

If so when? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

_____
Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

Thank you for filling out this form completely. It will enable us to help you more effectively. If you have any questions at any time, please ask us. We are happy to help.

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I verbally reviewed the medical / dental information above with the patient named herein. Initials_____ Date:_____

Doctor's Comments:_____

MEDICAL HISTORY UPDATE

1. Date:_____ Comments:_____ Signature:_____

1. Date:_____ Comments:_____ Signature:_____

1. Date:_____ Comments:_____ Signature:_____

Do you have a personal physician? Yes No

Physician's Name: ______________________

Office #: ______________ Last visit: ________

Medication List

Date	Medication	Dose	Frequency	Condition	Notes

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Cle Elum Dental Clinic. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Cle Elum Dental Clinic reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

STATEMENT OF PRIVACY PRACTICES

CLE ELUM DENTAL CLINIC

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR PERSONAL HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.