

# WELCOME

## 1

### ABOUT YOU

Today's Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ File #: \_\_\_\_\_

**Patient Name:** \_\_\_\_\_  
LAST FIRST MI

What You Prefer To Be Called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ SS#: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

CITY STATE ZIP

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Employer:** \_\_\_\_\_ How Long? \_\_\_\_\_

Employer's Address: \_\_\_\_\_

CITY STATE ZIP

Occupation: \_\_\_\_\_

Status:  Minor  Single  Married  Divorced  Separated  Widowed

Spouse's Name: \_\_\_\_\_

Do you have children?  Yes  No How many? \_\_\_\_\_

## 2

### INSURANCE INFO

Primary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

Secondary Dental Insurance

Co. Name: \_\_\_\_\_

Address: \_\_\_\_\_

CITY STATE ZIP

Phone #: (\_\_\_\_) \_\_\_\_\_

Insured's SS#: \_\_\_\_\_

Group # (Plan, Local, or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_

Relation: \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Insured's Employer: \_\_\_\_\_

## 4

### IN EVENT OF EMERGENCY

Whom should we contact? \_\_\_\_\_

Relation: \_\_\_\_\_

Home Phone #: (\_\_\_\_) \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

Cell Phone #: (\_\_\_\_) \_\_\_\_\_

Who is your Medical Doctor? \_\_\_\_\_

Medical Doctor's Phone #: (\_\_\_\_) \_\_\_\_\_

## 3

### ACCOUNT INFO

**Person ultimately responsible for account**

Name: \_\_\_\_\_

Relation: \_\_\_\_\_

Billing Address: \_\_\_\_\_

CITY STATE ZIP

SS #: \_\_\_\_\_

Drivers License #: \_\_\_\_\_

Work Phone #: (\_\_\_\_) \_\_\_\_\_

**Payment method:**  Cash  Check

Credit Card - Enter card # above (if accepted)

I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

PLEASE CONTINUE ON BACK 

Reason for today's visit:  Exam  Emergency  Consultation

Are you in pain?  No  Yes How Long? \_\_\_\_\_

Please indicate  any of the following problems:

Discomfort, clicking or popping in jaw.  Lost/Broken Filling(s)  Stained teeth

Red, swollen or bleeding gums.  Teeth grinding  Locking Jaw

Sensitive tooth, teeth or gums.  Ringing in Ears  Bad breath

Blisters/Sores in or around the mouth.  Broken/Chipped tooth

Other: \_\_\_\_\_

Do you require pre-medication?  Yes  No  Don't know

Previous Dentist: \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_  
Name Phone#

Last Dental exam: \_\_\_\_/\_\_\_\_/\_\_\_\_ Last Dental X-rays: \_\_\_\_/\_\_\_\_/\_\_\_\_

Times a day you brush? \_\_\_\_\_ Times a week you floss? \_\_\_\_\_

What type of tooth brush bristles do you use?  Soft  Medium  Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

## MEDICAL HISTORY

Are you taking any of the following medications?  Nerve pills  Pain killers (including aspirin)

Muscle relaxers  Stimulants  Blood Thinners  Tranquilizers  Insulin

Other(s), please list: \_\_\_\_\_

Do you have or have you had any of the following diseases, medical conditions or procedures?

- |                                    |                                    |                                       |                                     |
|------------------------------------|------------------------------------|---------------------------------------|-------------------------------------|
| <b>Y N</b> Heart Attack / Stroke   | <b>Y N</b> Thyroid Problems        | <b>Y N</b> Cancer/Tumors              | <b>Y N</b> Cosmetic Surgery         |
| <b>Y N</b> Heart Surg./Pacemaker   | <b>Y N</b> Kidney Problems         | <b>Y N</b> Shingles                   | <b>Y N</b> Xray or Cobalt Treatment |
| <b>Y N</b> Heart Murmur            | <b>Y N</b> Liver Problems          | <b>Y N</b> Hepatitis                  | <b>Y N</b> Chemotherapy             |
| <b>Y N</b> Rheumatic Fever         | <b>Y N</b> Respiratory Problems    | <b>Y N</b> HIV+/AIDS/ARC              | <b>Y N</b> Asthma                   |
| <b>Y N</b> Mitral Valve Prolapse   | <b>Y N</b> Sinus Problems          | <b>Y N</b> Arthritis/ Rheumatism      | <b>Y N</b> Difficulty Breathing     |
| <b>Y N</b> Artificial Valves       | <b>Y N</b> Stomach Problems/Ulcers | <b>Y N</b> Artificial Bones/Joints    | <b>Y N</b> Diabetes/Hypoglycemia    |
| <b>Y N</b> Heart Disease           | <b>Y N</b> Psychiatric Problems    | <b>Y N</b> Emphysema                  | <b>Y N</b> Leukemia                 |
| <b>Y N</b> Congenital Heart Defect | <b>Y N</b> Venereal Disease        | <b>Y N</b> Fainting/Seizures/Epilepsy | <b>Y N</b> Anemia                   |
| <b>Y N</b> Chest Pains             | <b>Y N</b> Alcohol/Drug Abuse      | <b>Y N</b> Severe/Frequent Headaches  | <b>Y N</b> High/Low Blood Pressure  |
| <b>Y N</b> Scarlet Fever           | <b>Y N</b> Tuberculosis TB         | <b>Y N</b> Frequent Neck Pain         | <b>Y N</b> Bleeding Problems        |
| <b>Y N</b> Nervousness             | <b>Y N</b> Jaw Problems TMJ/TMD    | <b>Y N</b> Back Problems              | <b>Y N</b> Glaucoma                 |

Please list any other surgeries or medical conditions you have or ever had: \_\_\_\_\_

Are you allergic to any of the following?  Latex  Penicillin / Amoxicillin  Tetracycline  Aspirin

Dental Anesthetics  Others: \_\_\_\_\_

Do you use tobacco?  No  Yes/How used? \_\_\_\_\_ How much? \_\_\_\_\_ How long? \_\_\_\_\_

Please rate your general health from 1-10: \_\_\_\_\_ Do you wear contact lenses?  Yes  No

Have you ever taken the drug Phen-fen and or Redux?  Yes  No

**For women:** Are you taking Birth Control pills?  Yes  No How many children have you had? \_\_\_\_\_

Are you Pregnant?  No  Yes/How long? \_\_\_\_\_ Are you nursing?  Yes  No

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Adult Patient  Parent or Guardian  Spouse

### UPDATE (OFFICE USE)

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

Initials \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Comments \_\_\_\_\_

## 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 IT CAREFULLY.

**The Health Insurance Portability & 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 purposes 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 for 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 alternatives 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 and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your 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 practice 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, 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 February 03, 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 date 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:**

Privacy Officer: Kami Petersen/Sandee Kuwahara  
Office Name: Pitzen Family Dentistry  
Address: 4303 Bridgeport Way W  
University Place, WA 98466  
Phone: (253)564-5545

**For more information about HIPAA or to file a complaint:**

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

**ACKNOWLEDGEMENT  
OF  
PRIVACY PRACTICES  
Pitzen Family Dentistry**

Michael T. Pitzen DDS  
4303 Bridgeport Way W  
University Place, WA 98466  
(253)564-5545

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 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:

\_\_\_\_\_  
\_\_\_\_\_

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**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