EZ Dental Clinic

Patient Information

First: _____ Middle: _____ Last: _____
Street: _____City: _____
State: _____ Zip:_____ Home Phone: _____
Work Phone:_____ Cell Phone: _____
Email Address: _____May we contact you by email? (circle) **Yes No**
Patient SSN # : _____Patient DOB: _____Sex: (circle) **M F**
Emergency Contact: _____Phone #:_____
Preferred Pharmacy: _____
How did you hear about us?
☐ Newspaper ☐ Facebook ☐ Website ☐ Referral ☐ Other: _____

Health Information

Physician's Name and Phone #: _____Reason for today's visit? _____

Have you been under the care of a physician? (circle) **Yes No**

Date of last dental visit: _____ Date of last dental x-rays: _____

Date of last cleaning: _____

Have you ever been treated for periodontal (gum) disease? (circle) **Yes No**

Are you interested in tooth whitening (circle) **Yes No**

If wearing dentures, age of dentures: _____ Are you interested in new dentures? **Yes No**

Have you taken antibiotics prior to dental procedures in the past? (circle) **Yes No**

Have you ever had an adverse reaction or become ill after taking penicillin, aspirin, codeine, local anesthetics, latex, metals, or any other medication? (circle) **Yes No**

List any medications you are allergic to:

1. _____ 2. _____ 3._____ 4. _____

List any medications you are taking:

_____
_____
_____

Do you have history of:

Alcoholism	Yes No	Psychiatric Treatment	Yes No	Aspirin/Anticoagulant therapy	Yes No
Any type of implant	Yes No	Cancer (type)	Yes No	Ulcers or stomach problems	Yes No
Any type of transplant	Yes No	Blood Transfusion	Yes No	Sinus Problems	Yes No
Diabetes	Yes No	Teeth grinding/clenching	Yes No	Pace Maker or Heart Surgery	Yes No
Drug addiction	Yes No	Heart Problem	Yes No	Excessive Bleeding	Yes No
Heart Murmur	Yes No	Allergies or Hives	Yes No	Epilepsy or Seizures	Yes No
Hepatitis (Type:)	Yes No	Dialysis	Yes No	Stroke	Yes No
High Blood Pressure	Yes No	HIV Positive/AIDS	Yes No	Latex Allergy	Yes No
Kidney Disease	Yes No	Radiation Treatment	Yes No	Breathing Problems	Yes No
Liver Disease	Yes No	Chemotherapy	Yes No	Lung Disease	Yes No
Mitral Valve Prolapse	Yes No	Anemia	Yes No	Fainting or Dizzy Spells	Yes No
Rheumatic Fever	Yes No	Ashtma	Yes No	Thyroid Disease	Yes No
Venereal Disease	Yes No	Arthritis	Yes No	Pain in your jaw (TMJ)	Yes No

Women patients only:

Is there a possibility of pregnancy? **Yes No** Are you nursing? **Yes No**

Estimated Delivery Date____/___/_____Are you taking any birth control prescriptions? **Yes No**

* NOTE: Antibiotics (such as penicillin) may alter the effectiveness of birth control pills. Consult your physician/gynecologist for assistance regarding additional methods of birth control.

Patients Signature_____ Date_____

Insurance Information

Do you have Dental Insurance? (circle) **Yes No**

Primary Insurance

Subscriber Name _____

Subscriber DOB _____

Relationship to: Self Spouse Child

Subscriber (circle)

Insurance Company _____

Insurance ID# _____

Insurance Group _____

Do you have Secondary Dental Insurance? (circle) **Yes No**

Secondary Insurance

Subscriber Name _____

Subscriber DOB _____

Relationship to: Self Spouse Child

Subscriber (circle)

Insurance Company: _____

Insurance ID# _____

Insurance Group _____

Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name: _____ Occupation: _____

Street: _____City: _____

State: _____ Zip: _____ Phone: _____

Financial Policies

At EZ Dental, we are committed to giving you exceptional service and providing treatment that addresses both your short-term and long-term needs. It is our optimal goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. We know you have a choice, and we appreciate your decision to trust us with your dental care. In order to keep our standard of care at a level which best serves your dental needs, we ask you to please observe the following guidelines.

1. A Clear Written Estimate on the Cost of Treatment

Your dentist will provide you with a comprehensive treatment plan after assessing your overall oral health. We'll provide a clear, detailed estimate of the cost for your treatment plan in writing so you know what to expect, including your estimated insurance benefits.

If you have any questions related to your insurance coverage, we encourage you to contact your insurance company.

2. Payment Policy

The following payment policies apply:

- Payment in full of the Patient Financial Responsibility amount, is due no later than when services are rendered. Acceptable forms of payment include cash, Visa, MasterCard, American Express, Care Credit.
- For comprehensive treatment plans requiring multiple office visits, a minimum deposit of 50% of the Patient Financial Responsibility amount is required.
- You may, at your discretion, elect to pay in full, in advance for comprehensive treatment plans.

* Patient Financial Responsibility: The patient is ultimately responsible for the payment of his/her treatment and care. The patient is responsible for any costs associated with collections of patient balances.

3. Dental Insurance

We accept assignment of insurance benefits, however, we do require your co-payment for deductibles to be paid at the time of service. The balance is your responsibility whether your insurance company pays or not.

Your insurance policy is a contract between you and your insurance company. We are not a party of that contract. If your insurance has not paid your account in full within 60 days, the entire balance will be payable by you.

4. Cancellation Policy

There are many times when our patients require urgent or emergency treatment and therefore need an appointment as soon as possible. When patients give the office advance notice of their need to cancel or reschedule, this time can then be allocated to those patients with immediate dental needs. In this way the office can best serve the dental needs of all patients. Bearing this in mind, our office requires a 48 hours' notice, the equivalent of two business days' notice, otherwise a $50.00 fee will be assessed.

AN ADULT MUST ACCOMPANY ALL MINORS DURING THE ENTIRE LENGTH OF THE MINOR'S APPOINTMENT.

I have read the above policies of E.Z. Dental Clinic and understand my responsibilities as a patient.

Date_____ Patient Signature_____

EZ Dental Clinic

Notice of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect 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 (HIPAA) 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 to anyone – even family members – without your written consent. 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 of 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 Health Information

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 Health 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 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.

Patient Rights

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.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

EZ Dental Clinic

Receipt of Treatment Plan & Financial Policies

1. Payment, Insurance, and Financial Arrangement Policies (must be signed by ALL new patients).

By signing below, I acknowledge that I received the Financial Policies form and agree to abide by such policies.

Signature _____ Date _____

(If patient is a minor or disabled, the Parent, Guardian or Power of Attorney must sign and complete the Responsible Party section below)

2. Notice of Privacy Practices (must be signed by ALL new patients).

By signing below, I acknowledge that I have read the Notice of Privacy Practices, as mandated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")

Signature _____ Date _____

3. Release of Information to Insurers and Assignment of Benefits (must be signed by all new patients with insurance and those who expect to obtain insurance).

To the extent permitted by law, I consent to my practices (or their designees) use and disclosure of my Protected Health Information to carry out payment activities in connection with my insurance claim. This information will be used exclusively for the purpose of evaluating and administering claims for benefits. I further authorize and direct payment to my practice of the dental benefits otherwise payable to me.

Signature_____ Date _____

(If patient is a minor or disabled, the Parent, Guardian or Power of Attorney must sign and complete the Responsible Party section below)

4. Consent to obtain medication history.

To the extent permitted by applicable law, I authorize this dental practice (or their designees) to collect information about my prescription history from my pharmacy and insurers (as applicable) and give my pharmacy and insurers permission to disclose such information. This includes prescription information related to medicines to treat AIDS/HIV and medicines used to treat mental health issues.

Signature _____ Date _____

(If patient is a minor or disabled, the Parent, Guardian or Power of Attorney must sign and complete the Responsible Party section below)

EZ Dental Clinic

Responsible party (if patient is under 18 or disabled)

The following is for: ☐ the patients spouse ☐ the patient's parent/guardian

☐ the person responsible for payment

First: _____Middle: _____ Last: _____

Street: _____City: _____

State_____ Zip_____

Home Phone: (____) _____ Work Phone: (_____) _____

Cell: (____) _____

Patient SSN: _____-_____-_____ Patient Date of Birth: _____/_____/_____ Sex:(circle) **M** **F**

Signature: _____Date: _____

*Retain Original in Patient's Chart

Authorization for Release of Health Records to External Parties

I authorize disclosure of information from my treatment records to:

Name of Recipient: _____ _____

Relationship to the patient: _____

I give authorization to disclose the following information:

☐ All my treatment information

☐ Information specifically related to these treatment dates

Starting Date: _____ End Date: _____

I understand that I may withdraw or revoke my permission at any time. I may revoke this authorization by notifying EZ Dental in writing.

Signature of patient (or patient representative) _____

Date _____

Printed Name of Patient (or patient representative) _____

Date _____