PATIENT RECORD

DATE: _____________

NAME: ____ SOC. SEC. #:______________________________

ADDRESS: ____ DATE OF BIRTH: _____________________________

CITY: ____ STATE: ____________ ZIP: ___________________

PHONE (H):___________________ CELL: ____________________ EMAIL: ___________________________________

EMERGENCY CONTACT: ____________________________________ PHONE #: ____________________________

DENTAL INSURANCE CARRIER: _______________________________ ID#: _______________________________

NAME OF SUBSCRIBER: __________________________________ SUBSCRIBER DOB: _____________________

OTHER DENTAL INSURANCE: ____

DENTIST: _____________________________________ PHYSICIAN: ____

PRIVACY PRACTICES

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 Notices 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 this address 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.

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we request payment at the time services are rendered. For your convenience we will accept Cash, Check, Visa, MasterCard, American Express, Discover or Care Credit. If you have dental insurance, please be sure our office has your current dental insurance information before the time of your initial visit. We will gladly assist you in completing and submitting your claim. We do not submit predeterminations prior to treatment. Please know not all services are covered by insurance companies (e.g. *EdgePro Technology*, CBCT Scans). Fees for **all** endodontic services are the responsibility of the patient and we do not render services based on payment or denial by insurance companies. ***It is the responsibility of the patient to know the allowances and limitations of his or her own policy*.** Any difference between estimated benefits and actual payment will be the responsibility of the patient. When signing below you are agreeing to the above and allowing Skagit Endodontics to collect billed charges for services denied as "non-covered" by your insurance company.

FINANCIAL ARRANGEMENTS

We Accept the following payment options:

Cash or Check
Discover
American Express
MasterCard
Visa
Care Credit

FINANCIAL AGREEMENT, AUTHORIZATION AND RELEASE:

I authorize the doctor to release any examination, diagnosis or treatment information regarding me or my dependent to third party payers and/or health practitioners. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependents. If this account is not paid for in full, a service charge of 1.5% per month, which is 18% per annum, will be charged on all balances of 30 days or greater. A minimum $5 late charge will be assessed on your account. If this account is not paid as agreed, and legal action is commenced to collect the amount due, I/we agree that in addition to the other charge herein, I/we will pay reasonable attorney fees. At the request of either party, venue for any legal action shall be placed in Skagit County, WA.
I certify that I have read and understand the above
Privacy Practices and Financial Policy Statement and to the best of my knowledge all medical History questions have been accurately answered.

***Per WA State Law all minors under the age of 18 must be accompanied by a parent or legal guardian. They also must remain present during the appointment.**

Date: ____

Signature: ____________________________________
Signature of Patient (or Parent/ Guardian if patient is a minor)

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 Skagit Endodontics. 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.

Skagit Endodontics 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:**	

PATIENT MEDICAL HISTORY

Name: ____________________

Has there been any change in your general health within the last 2 years? YES NO

If yes, please specify ____

____

Are you currently taking any medications? (Including non-prescription medications.) YES NO
If yes, please specify or provide list. ____

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Have you ever been treated for Infective Endocarditis (infection of the heart lining)**?** YES NO
Have you received therapy for alcoholism or drug addiction within the last five years? YES NO
If yes, please specify.____
Have you ever had any allergic or adverse reactions to Latex, anesthetics, antibiotics, or other medications or substances? YES NO If yes, please specify below: ________________________

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Are you currently taking or have you taken bisphosphates or anti-resorptive medications for bone density or cancer treatment? (E.g. Fosamax, Actonel, Zometa, Aredia, Boniva, Denosumab). YES NO
If yes, when? ____

Are you required to pre-medicate with antibiotics prior to dental procedures? YES NO

If yes, for what condition and when e.g. artificial joint, heart valve, MVP. ________________________________

____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS: (please circle all that apply)

Heart disease	Excessive Bleeding	Osteoporosis	Angina Pectoris
Cancer / Tumor	Hepatitis A or E	Hepatitis B or C	HIV / AIDS
Radiation	Heart Murmur	Emphysema	Liver Disease
Rheumatic Fever	Tuberculosis (TB)	Blood Transfusion	Congenital Heart Defect
Asthma / COPD	Prosthetic Heart valve	Sinus Trouble	Hemophilia
Cardiac Pacemaker	Allergies or Hives	Epilepsy or Seizures	Heart Surgery
Diabetes	Fainting or Dizziness	Artificial Joint	Thyroid Disease
Nervousness	Anemia	Chemotherapy	Psychiatric Treatment
Stroke	Bruise easily	Kidney/ Renal Disease	Glaucoma
Heart failure	Ulcers	TMJ	Heart Attack
Infective Endocarditis	High / Low Blood Pressure	Sexually Transmitted Disease	Cortisone (Steroid) Medications

WOMEN ONLY:

Are you pregnant or think you may be pregnant? *YES NO*
Are you nursing? *YES NO*
Are you taking oral contraceptives? *YES NO*
If yes, please be advised that if you take antibiotics, an alternate method of birth control must be used