TANIA TRAN DMD
GROVE STREET FAMILY DENTISTRY
1533 Grove Street • Marysville, WA 98270
(360) 659-3200

Welcome to Our Office

Name: _____
First MI Last Title

Preferred Name: _____

Address: _____
Street City State ZIP

SSN: _____ DOB: _____ ☐ Male ☐ Female

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Occupation: _____ Employer: _____

How did you hear about our office? _____

How do you prefer to be contacted: ☐ phone ☐ email or ☐ text?

Insurance – Primary

Insurance Company Name: _____

Subscriber Name: _____

Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Group Number: _____

Subscriber Employer: _____

Insurance – Secondary

Insurance Company Name: _____

Subscriber Name: _____

Relationship to Patient: _____ Subscriber DOB: _____

Subscriber SSN/ID: _____ Group Number: _____

Subscriber Employer: _____

Assignment and Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Tania Tran DMD PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Consent

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care

Patient/Guardian Signature: _____

Relationship: _____ Date: _____

Medical History

TANIA TRAN DMD
GROVE STREET FAMILY DENTISTRY

Name: _____
Are you now under the care of a physician? ☐ Yes ☐ No
Physician's Name: _____
Physician's Phone #: _____ Date of last physical exam: _____
Your current physical health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Please list conditions you are currently being treated for: _____

_____

Do you use tobacco in any form? ☐ Yes ☐ No
Are you taking any medications? ☐ Yes ☐ No
Please list each one: _____

_____

Have you had any serious illness, operation or hospitalization? ☐ Yes ☐ No
Please list each event and date: _____

_____

Please <u>check</u> if you have a history of the following diseases or problems:

☐ Abnormal Bleeding
☐ Alcohol Abuse
☐ Allergies
☐ Anemia
☐ Angina Pectoris
☐ Arthritis
☐ Artificial Heart Valve
☐ Asthma
☐ Blood Transfusion
☐ Cancer
☐ Chemotherapy
☐ Colitis
☐ Congenital Heart Defect
☐ Diabetes
☐ Difficulty Breathing
☐ Drug Abuse
☐ Emphysema
☐ Epilepsy
☐ Facial Surgery
☐ Fainting Spells
☐ Fever Blisters
☐ Frequent Headaches
☐ Glaucoma
☐ HIV + AIDS
☐ Heart Attack
☐ Heart Murmur
☐ Heart Surgery
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B
☐ Hepatitis C
☐ High Blood Pressure
☐ Joint Replacement
☐ Kidney Problems
☐ Liver Disease
☐ Low Blood Pressure
☐ Mitral Valve Prolapse
☐ Pace Maker
☐ Psychiatric Problems
☐ Radiation Therapy
☐ Rheumatic Fever
☐ Seizures
☐ Sexually Transmitted Disease
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Problems
☐ Stroke
☐ Thyroid Problems
☐ Tuberculosis
☐ Ulcers

<u>Allergies</u> (*list type of reaction*)
☐ Aspirin _____
☐ Codeine/narcotics_____
☐ Dental Anesthetics _____
☐ Penicillin/antibiotics_____
☐ Sulfa drugs_____
☐ Latex _____
☐ Metals _____
☐ Other_____

<u>Women Only</u>
Are you pregnant? ☐Yes ☐No ☐DK
If yes, how many weeks? _____
Are you using birth control or hormone replacement? ☐Yes ☐No
Are you nursing? ☐Yes ☐No

Emergency Contact Person:
Name: _____
Relationship: _____ Phone Number: _____

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 of confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature: _____ Date: _____

Dental History and Consent for Treatment

TANIA TRAN DMD
GROVE STREET FAMILY DENTISTRY

Name: _____

Reason for seeking dental care at this time: _____

_____

Date of last dental visit: _____Date of last dental radiographs: _____
Former dentist: _____City/State: _____
How often do you: Brush _____ Floss_____ Type of toothbrush: _____
How do you feel about dental treatment? ☐Relaxed ☐A little uneasy ☐Tense ☐Anxious ☐Very Anxious

Do you have or have you ever had any of the following? Please mark boxes.

☐ Aching or sensitive teeth	☐ Broken filling	☐ Areas of food traps
☐ Loose teeth	☐ Unfavorable dental experience	☐ Sensitive or bleeding gums
☐ Difficulty opening wide	☐ Growths or lesions in your mouth	☐ Broken or missing teeth
☐ Bad breath	☐ Clicking or popping jaw	☐ Cold sores
☐ Grinding or clenching	☐ Swollen glands	☐ Jaw pain or tiredness
☐ Dry mouth	☐ Swelling or lumps in mouth	☐ Gum infection
☐ Orthodontic treatment	☐ Gag easily	☐ Facial surgery
☐ Oral Surgery	☐ Esthetic concerns with teeth	☐ Other_____

Why did you leave your previous dentist? _____
How can we accommodate you better during your dental visit? _____

If you could change your smile, what would you change?

☐ Remove unsightly fillings	☐ Straighten teeth	☐ Change shape of teeth	☐ Close gaps between teeth
☐ Replace missing teeth	☐ Whitening	☐ Make teeth same color	☐ Other _____

Consent

I, the undersigned, hereby authorize the doctor to take radiographs, study models, photographs, or any other diagnostic aids she/he deems appropriate to make a thorough diagnosis of my dental needs. I also authorize the doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I authorize and consent that the doctor may employ any such assistance as she/he deems appropriate.

I further authorize the release of any information, including the diagnosis, radiographs and records of any treatments or examinations rendered to my insurance company, consulting professionals or others that may request my records. I understand that I am personally responsible for payment of all fees for dental services provided in this office for me or my dependents, regardless of insurance coverage. Breach of this responsibility carries the penalty of compensating the practice for any related attorney's and collection fees. I understand that payment is due when services are rendered. Any other arrangements for payment must be made before treatment begins.

_____ _____ _____
Signature of patient or authorized responsible party | Relationship | Date

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Financial Policies

We have several financial policy options available for your convenience in receiving the proper dental care. We have found that our patients appreciate knowing exactly what dental financial responsibilities they will incur. Therefore, we inform our patients about our financial policies before we begin treatment. Knowing this ahead of time allows us all to arrange for the completion of the necessary dental treatment.

- **Dental Insurance**
  Most insurance companies will not cover 100% of all dental expenses. Your portion, not covered by insurance, is due at the time treatment is performed.
  Please understand that dental insurance is a contract between the patient and the insurance carrier, and not between the insurance carrier and the dentist. The patient is still the responsible party regarding dental fees. We will be glad to process your insurance forms at no charge.
  Please be aware that we are only capable of approximating your portion due to the large number of insurance companies and to their periodic changes within their contracts without notifying each dental office of these changes.

- **Cash or Check**
  Payment in full is due when services are performed.

- **Mastercard, VISA, American Express or Discover**

- **Care Credit**
  We've made arrangements with Care Credit that will fiancé your dental work with approved credit. No interest payment plans are available. This will allow you to complete your dental work without delay and make relatively small monthly payments. Application forms are available at the reception desk.

- **5% Prepayment Bookkeeping Courtesy**
  On services over $100, a 5% reduction will be given when paid in full prior to that appointment date. A refund will be made if the proposed treatment is not completed.

- **Senior Citizen Courtesy**
  For our patients 65 years or older, we offer a 5% fee reduction. On services over $100, an additional 5% reduction will be given if paid prior to your appointment date.

- **Gradual Treatment Plan**
  If it will be easier financially for those patients without dental insurance, we can plan the completion of your dental work by spreading your appointments over several months or years. We will arrange to do the more urgent services at the beginning of treatment.

A specific amount of time is reserved especially for your and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hour notice**.

Responsible Party Signature: _____

Relationship: _____ Date: _____

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 Grove Street Family Dentistry. 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.

Grove Street Family Dentistry 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, personal protected (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, Children's Spouses)	☐ YES	☐ NO
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ YES	☐ NO
OTHER:	☐ YES	☐ NO

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative's signature:

Representative's Telephone 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 OVERVIEW

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 HEALTH 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 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 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.

IF you'd like a full and complete copy of our Statement of Privacy Practices, please ask at the front desk.