Client Information

Name _____ Preferred Name _____

Address _____ Birthdate _____

City, Zip Code _____ S.S.N_____

Home Phone _____ Work Phone _____ Cell _____

Employer _____ Occupation _____ Location _____

May we contact you at work? Yes☐ No ☐ When is the best time to contact you? _____

Appointment reminders by: ☐ Home ☐ Work ☐ Cell ☐ Text ☐ Email _____

Emergency Contact Person_____ Phone _____

Whom may we thank for referring you? _____

Please complete if you would like us to bill your medical benefit.

Subscriber's Name _____ Birthdate _____

Subscriber's Residence_____ Phone _____

City, State, Zip Code _____ S.S.N. _____

Subscriber's Employer _____ Work Phone _____

Name of Insurance Company_____ Phone _____

Address of Insurance Company _____ ID Number _____

City, State, Zip Code _____ Group Number _____

Patient's relationship to subscriber: Self ☐ Spouse ☐ Child ☐ Misc ☐_____

What brought you into our office today?

☐ Snoring
☐ Partner says I stop breathing during the night
☐ CPAP Intolerance
☐ I've been diagnosed with Sleep Apnea and want an oral appliance

Other services or questions?

_____

_____

HEALTH ASSESSMENT

1. Have you seen a medical doctor during the past two years? ..... Yes ☐ No☐

   Name of Physician: _____ Physician's Phone: _____

2. Have you ever been hospitalized? ..... Yes ☐ No☐

3. Have you taken any medicine or drugs during the past two years? ..... Yes ☐ No☐

   Please list: _____

   _____

4. Are you allergic to or made sick by penicillin, aspirin, codeine, local anesthetics
   or any other drugs or medications? ..... Yes ☐ No☐

   Please list: _____

   _____

5. Have you ever had a reaction to local anesthetics
   or any medical complication associated with any dental experience? ..... Yes ☐ No☐

6. Do you have reaction to metal jewelry? ..... Yes ☐ No☐

7. Have you ever had any excessive bleeding requiring special treatment? ..... Yes ☐ No☐

8. When you walk up stairs or take a walk, do you ever have to stop because of
   pain in your chest or shortness of breath, or because you are very tired?..... Yes ☐ No☐

9. Do you ever wake up from sleep short of breath? ..... Yes ☐ No☐

10. Do you have difficulty laying on your back and breathing? ..... Yes ☐ No☐

11. WOMEN: Are you pregnant, trying to become pregnant or nursing? ..... Yes ☐ No☐

12. Please circle any of the following that you have had or have at present:

Heart Failure
Heart Disease or Attack
Angina Pectoris
High Blood Pressure
Low Blood Pressure
Heart Murmur
Rheumatic or Scarlet Fever
Congenital Heart Defects
Artificial Heart Valve
Heart Surgery or Pacemaker
Artificial Joint
Organ Transplant
Mental Health Issues
Psychiatric Treatment
Herpes
Cold Sores or Fever Blisters
Latex Allergy
Use of Diet Drugs
Major Surgery
Cosmetic Surgery

Kidney Trouble
Ulcers
Diabetes
Alcohol or Drug Dependence
Epilepsy or Seizures
Stroke
Cancer/Tumor
Thyroid Problems/Disease
Radiation or Cobalt Treatment
Chemotherapy
Allergies or Hives
Asthma
Emphysema or Bronchitis
Tuberculosis (TB)
Persistent Cough
Arthritis or Swollen Joints
Rheumatism
Cortisone Medicine
Glaucoma
Pain in Jaw Joints

HIV+/AIDS
Hepatitis A (infectious)
Hepatitis B (serum)
Hepatitis C
Liver Disease or Yellow Jaundice
Anemia
Blood Transfusion
Hemophilia
Bruise Easily
Sickle Cell Disease
Sinus Trouble or Hay Fever
Fainting or Dizzy Spells
Tobacco Use Current
Tobacco Use Past
Sleep Apnea
CPAP
Snoring
Fibromyalgia

Notes: _____

_____

CONTINUED ON OTHER SIDE

DENTAL HEALTH ASSESSMENT

1. Are you currently seeing a dentist? .....Yes ☐ No☐

2. When was your last dental appointment? _____

3. Do you wear dentures or partials? .....Yes ☐ No☐

4. Does your jaw ever feel sore or tired? .....Yes ☐ No☐

5. Do you grind or clench your teeth? ..... Yes ☐ No☐

If yes, when? ..... Day ☐ Night ☐ Both ☐

6. Are you able to chew comfortably on both sides of your mouth? ..... Yes ☐ No☐

11. Have you ever had:

- ❑ Jaw Joint Problems
- ❑ Headaches
- ❑ Neck and Shoulder Pain
- ❑ TMJ
- ❑ Sore Muscles
- ❑ Bite Problems

12. Have you ever seen other health care professionals?

- ❑ Chiropractor
- ❑ Physical Therapist
- ❑ Ear, Nose & Throat Doctor
- ❑ Massage Therapist
- ❑ Neurologist
- ❑ Orthodontist

13. Do you have any medical condition or problem not listed on this form? ..... Yes ☐ No ☐

_____

_____

TO THE BEST OF MY KNOWLEDGE ALL OF THESE ANSWERS ARE TRUE AND CORRECT. IF I HAVE ANY CHANGE IN MY HEALTH OR IF MY MEDICINES CHANGE I WILL INFORM DR. TAYLOR/ DR. CARROLL AT OR PRIOR TO MY NEXT APPOINTMENT.

_____ _____

Signature of Patient, parent or guardian Date

Welcome!

We feel strongly that our patients deserve the best possible care we can provide. In an effort to provide and maintain that high quality care, we would like to share some information with you about financing your dental care. Our hope is that by providing you with the following information we can prevent misunderstandings and that you will be comfortable discussing financial and insurance matters with us. We urge you to consult with us if you any questions regarding our fees and/or services.

FINANCIAL EXPECTATIONS

- After your first visit we ask that you make full payment unless other arrangements have been made. If you have medical insurance we ask that you pay that portion which your insurance does not pay.
- We accept cash, personal checks and major credit cards.
- We also partner with CareCredit and Springstone Finance. *Let us know if you're interested.*
- Outstanding balances are due in full within 30 days of service unless other arrangements have been made. A finance charge of 1.5% per month (18% per year) will be assessed to balances over 90 days past due. Please feel free to talk to us about **any** concerns.
- A 48 hour notice is required for any appointment changes to avoid a possible cancellation fee of $75.
- Delinquent accounts will be referred to a collection agency.

I, _____, understand the financial expectations of Dental Sleep Northwest.

Signed: _____Date: _____

Medical INSURANCE

Many patients are under the impression that if they have insurance coverage it is the insurance company that owes the provider for any services rendered. The insurance contract is actually **between the patient and the insurance company**. Therefore the patient is responsible for all account balances regardless of any insurance benefit. As a courtesy to our patients we are happy to bill your insurance company for you. Please be sure to provide us with **correct and complete** information so we may process your claim in an **accurate and timely** manner. Insurance companies use the term "**usual and customary**" when establishing fee limitations for services rendered. The benefits paid by your plan are largely determined by how much your employer/union paid for the plan. Please be aware that insurance companies will pay a claim percentage based on their "usual and customary" fees, not our actual fees. Thus your insurance coverage may be less then you expected. We encourage you to be familiar with your plan benefits.

I, _____, authorize Dental Sleep Northwest to release any information required for payment or review of my (or my dependent's) claim(s). I hereby authorize my insurance benefits to be paid directly to the dentist and I am responsible for any balance due.

Signed: _____ Date: _____

Acknowledgement of Receipt of Statement of Privacy Practices

I, _____, acknowledge that I have received a copy of the Statement of Privacy Practices for Dental Sleep Northwest. This statement describes the types of uses and disclosures of my protected health information, my rights, and the responsibilities and duties of this office with respect to my protected health information.

Dental Sleep Northwest reserves the right to change their privacy practices. If the privacy practices change, I will be offered a revised copy on my first visit after the changes become effective.

Signature: _____Date: _____

In addition, HIPPA privacy laws and regulations require us to obtain signed approval to leave voicemail or messages with an individual regarding your appointment on the number(s) you have provided.

May we leave a voicemail/message regarding your appointment?

_____ Yes

Who: _____

_____ No

*I understand the default answer is "NO." Without indicating "YES," my information may not be shared with anyone unless allowed by HIPPA rules.

Signature: _____ Date: _____

OFFICE USE ONLY: Accepted ☐ Declined ☐ _____

Statement 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 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 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, 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 quality of 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 appointments including voice mail messages, answering machines, and postcards unless you direct us otherwise. We will never use disclose, cell, 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 HIPPA Privacy 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 may 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.