Patient Information

Name (first, last, middle initial): _____ DOB: _____

Preferred Name: _____ SS#: _____ Sex/Gender: _____

Address: _____ City: _____ State: _____ Zip : _____

Home #: _____ Cell #: _____ Work #: _____

Email: _____ Preferred Method of Contact: _____

Text OK? ☐ YES ☐ NO Detailed voice message OK? ☐ YES ☐ NO

Employer: _____ Occupation: _____

Previous Dentist: _____ Last Visit Date: _____

How did you hear about us? _____

Emergency Contact

Name: _____ Relation: _____ Phone #: _____

Responsible Party

Name: _____ Birth Date: _____ SSN#: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____ Employer: _____

PRIMARY DENTAL INSURANCE

Employer: _____

Ins. Co. Name: _____

Address: _____ Ins. Phone: _____

Subscriber: _____ **Phone:** _____

Relation to Patient: _____ **DOB:** _____

Subscriber ID: _____

Group#: _____ **Group Name:** _____

SECONDARY DENTAL INSURANCE

Employer: _____

Ins. Co. Name: _____

Address: _____ Ins. Phone: _____

Subscriber: _____ **Phone:** _____

Relation to Patient: _____ **DOB:** _____

Subscriber ID: _____

Group#: _____ **Group Name:** _____

I understand that the information I have provided today is to the best of my knowledge, and that it is my responsibility to update the office with any changes to this information.

Patient Signature: _____ DATE: _____
(Parent or Guardian if minor)

Medical History

Patient Name: _____ Date of Birth: _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive.
Thank you for answering the following questions.

Women: Are you...

Pregnant/Trying to get pregnant? ☐ Yes ☐ No Taking oral contraceptives? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No

Are you under a physician's care now? ☐ Yes ☐ No If yes, Doctor's name: _____

Have you ever been hospitalized or had a major operation?? ☐ Yes ☐ No If yes, please explain: _____

Have you ever had a serious head or neck injury? ☐ Yes ☐ No If yes, please explain: _____

Do you take or have you ever taken Phen-Fen or Redux? ☐ Yes ☐ No

Have you ever taken Fosamax, Boniva, Actonel or any other bisphosphonate medications? ☐ Yes ☐ No If yes, please explain: _____

Are you on a special diet? ☐ Yes ☐ No If yes, please explain: _____

Do you use tobacco? ☐ Yes ☐ No If yes, please explain: _____

Do you use controlled substances? ☐ Yes ☐ No If yes, please explain: _____

Are you taking any medications, pills, or drugs? ☐ Yes ☐ No

If yes, please list them: _____

Are you allergic to any of the following?

☐ ASPIRIN ☐ PENICILLIN ☐ CLINDAMYCIN ☐ LATEX
☐ CODEINE/NARCOTICS ☐ LOCAL ANESTHETICS ☐ SULFA DRUGS ☐ ACRYLIC
☐ VALIUM or OTHER TRANQUILIZERS ☐ OTHER: _____

Please check the box if you have or have had any of the following:

☐ AIDS/HIV	☐ DIABETES	☐ HEMOPHILIA	☐ RECENT WEIGHT LOSS
☐ ALZHEIMER'S DISEASE	☐ DRUG ADDICTION	☐ HEPATITIS	☐ RENAL DIALYSIS
☐ ANAPHYLAXIS	☐ EASILY WINDED	☐ HERPES	☐ RHEUMATIC FEVER
☐ ANEMIA	☐ EMPHYSEMA/COPD	☐ HIGH BLOOD PRESSURE	☐ RHEUMATISM
☐ ARTHRITIS/GOUT	☐ EPILEPSY/SEIZURE DISORDER	☐ HIGH CHOLESTEROL	☐ SCARLET FEVER
☐ ARTIFICIAL HEART VALVE	☐ EXCESSIVE BLEEDING	☐ HYPOGLYCEMIA	☐ SINUS TROUBLE
☐ ASTHMA	☐ FAINTING SPELLS/DIZZINESS	☐ KIDNEY PROBLEMS	☐ SLEEP APNEA
☐ BLOOD DISEASE	☐ FREQUENT COUGH	☐ LEUKEMIA	☐ SPINAL BIFIDA
☐ BLOOD TRANSFUSION	☐ FREQUENT DIARRHEA	☐ LIVER DISEASE	☐ STOMACH/INTESTINAL DISEASE
☐ BREATHING PROBLEMS	☐ FREQUENT HEADACHES	☐ LOW BLOOD PRESSURE	☐ STROKE
☐ BRUISE EASILY	☐ LUNG DISEASE	☐ MALIGNANT HYPERTHERMIA	☐ SWELLING OF LIMBS
☐ CANCER	☐ GLAUCOMA	☐ MITRAL VALVE PROLAPSE	☐ THYROID DISEASE
☐ CHEMOTHERAPY	☐ HAY FEVER	☐ OSTEOPOROSIS	☐ TONSILLITIS
☐ CHEST PAINS	☐ HEART ATTACK/FAILURE	☐ PAIN IN JAW JOINTS/TMJ	☐ TUBERCULOSIS
☐ COLD SORES/FEVER BLISTERS	☐ HEART MURMUR	☐ PARATHYROID DISEASE	☐ TUMORS OR GROWTHS
☐ CONGENITAL HEART DISORDER	☐ HEART PACE MAKER	☐ PSYCHIATRIC CARE	☐ ULCERS
☐ CORTISONE MEDICINE	☐ HEART TROUBLE/DISEASE	☐ RADIATION THERAPY	☐ YELLOW JAUNDICE

Have you ever had any illness (minor or serious) not listed above? ☐ Yes ☐ No

If yes, please explain: _____

I certify that I have read and I understand the questions above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I understand that it is my responsibility to update the office with any changes to this information and that any errors or omissions that I have made in the completion of this form are the responsibility of my own.

Patient Signature: _____ Date: _____
(Parent/Guardian if minor)

I certify that I have reviewed my previous answers to the questions above. I hereby state that the information above remains unchanged.

Patient Signature: _____ Date: _____
(Parent/Guardian if minor)

Appointment Cancellation Policy Agreement

Oasis Dental is committed to providing all our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at (360)695-3369 by 12:00PM on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please call our office by 2:00PM on Thursday. If prior cancellation notice is not given as stated above, you will be charged a fee of $50.00 for the missed appointment.

Please sign below to consent to these terms.

PATIENT/GUARDIAN SIGNATURE: _____ DATE: _____

PATIENT NAME:_____ DOB:_____

We are pleased to assist you with your dental insurance. If you have dental insurance, please be aware that insurance quotes are an ESTIMATE based on the information we are given by your insurance company. Coverage may be different if your deductible has not been met, annual maximum has been met, or your coverage table is lower than average.

Co-Pays:

I understand that I am responsible for all co-payment at the time of service, prior to leaving.

Deductibles:

I acknowledge that I assume full financial responsibility for services rendered to me if my insurance carrier denies or does not cover my claim for these services. I understand the terms of this form and accept financial responsibility with or without the use of my insurance coverage.

_____

PATIENT SIGNATURE (PARENT OR GUARDIAN IF MINOR) DATE

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 receives 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.

Oasis Dental

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 Oasis Dental. 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.

Oasis Dental 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.)

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: (Name)	**Telephone #:**	☐ **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**	