REGISTRATION AND INFORMATION

Please print the following information.

This information is important for our records and your health, and is of course **confidential.**

Patient's Name: _____ Date of Birth: _____ Age: _____
Last First Middle Initial

Name I prefer to be called: _____Parents Name _____
(if patient is under age 18)

Marital Status: Single ___ Married ___ Widowed ___ Divorced ___ Number of Children_____

Spouse's Name: _____ Best contact number: _____-_____-_____

Home Address: _____
Street City Zip

Please check how you prefer to be contacted: ☐Home: _____-_____-_____

☐Cell: _____-_____-_____**txt?**__ ☐Work: _____-_____-_____☐Other: _____-_____-_____

☐Email: _____

Employer: _____ Occupation: _____

Person we may contact in case of an emergency (other than your family home): _____

_____
Relationship Home # Work # Cell #

Former Dentist: _____
City State Phone number

Who may we THANK for referring you? _____

I hereby authorize my insurance benefits (if any) be paid to McPhee Dental Group.
I authorize McPhee Dental Group to release any information for insurance claims. I authorize that my records may be used by the doctor if he/she so determines. I consent to the making of videotape, photographs, and x-rays before, during and after treatment, also to be used by the same doctor in scientific papers or demonstrations.

I certify that I have read or have had read to me the contents of this form and do realize the risks and limitations involved. I will be responsible for any bill incurred on myself or family for dental treatment. Terms: cash in thirty (30) days – all past due accounts over ninety (90) days are subject to 1.5% monthly finance charges, minimum amount $1.00. Client assumes all responsibilities for collection fees, collection costs, attorney fees and court costs.

Person responsible for payment of this account: _____

Relationship to patient: _____

Signed: _____ Date: _____

Medical History

Patient Name: _____ Date of Birth: _____

Name of Medical Physician: _____ Last physical examination:_____

How would you rate your general health? **Good: _____ Fair: ____ Poor: ____**

Do you have or have you ever had, any of the following?

YES NO

___ ___ Heart Problems
___ ___ Heart Murmur/Mitral Valve Prolapse
___ ___ Heart Surgery: Bypass / Valve surgery
___ ___ Heart Attack: When: _____
___ ___ Wearing a Pacemaker
___ ___ Stroke: When: _____
___ ___ Abnormal Blood Pressure: High / Low
___ ___ Do you have / get frequent chest pains?
___ ___ Do you have shortness of breath?
___ ___ Have you been hospitalized or had any surgeries in the past 3 years? Yes / No
_____
___ ___ Diabetes
___ ___ Bleeding problems or bruise easily or blood disorder
___ ___ Blood transfusion, when: _____
___ ___ Taking a blood thinner or aspirin regimen
___ ___ Anemia
___ ___ Hepatitis: Type:_____ Date: _____
___ ___ Lung trouble: Asthma, emphysema, or COPD
___ ___ Kidney Disease
___ ___ Liver Disease or Jaundice
___ ___ Auto Immune Disorder
___ ___ HIV / AIDS
___ ___ Osteoporosis
___ ___ Arthritis
___ ___ Cancer / Tumor _____
___ ___ Chemotherapy or radiation therapy
___ ___ Fainting spells, seizures or epilepsy
___ ___ Frequent headaches or spells of dizziness
___ ___ Sinus Trouble
___ ___ Oral Herpes (cold sores, fever blisters)

YES NO

___ ___ Visual Disorder
___ ___ Hearing Loss: Right / Left side(s)
___ ___ Do you have a Latex Sensitivity?
___ ___ Alcoholism / Drug dependency
___ ___ Are you following a special diet?
___ ___ Prosthetic joints (Hip, Knee, etc.)
When: _____
___ ___ Have you been told you require antibiotics for routine dental treatment?
___ ___ Are you under a physician's care? If yes what for: _____
___ ___ Are you taking any medications? (Including over-the-counter medications)
Please list: _____
_____
_____
___ ___ Are you **allergic** to or had a **reaction** to any medications? List: _____
_____
_____
___ ___ Hives or skin rash from tree/milk products
___ ___ Past or present eating disorder (bulimia, anorexia) _____
___ ___ Digestive Disorder _____

MALE:

___ ___ Prostate disorder

FEMALE:

___ ___ Taking birth control pills / other:_____
___ ___ Are you or suspect that you are pregnant? Due Date: _____
___ ___ Hormone replacement therapy?
___ ___ Any other **Medical disease, condition or problem** not listed above that we should be aware of?: _____
_____
_____

Signature: _____

Date: _____

Please do not write below this line, for office use only.

_____

_____

DENTAL HISTORY

Patients Name: _____ Date of Birth _____

Do you have or have you had any of the following?

YES	NO		This column for office use
___	___	Trouble with dental anesthetics	_____
___	___	Any missing teeth?	_____
___	___	Aware of any uncomfortable bite	_____
___	___	Foods catch between your teeth	_____
___	___	Any part of your mouth sensitive to temperatures	_____
___	___	Had a blow to the jaw (trauma)	_____
___	___	Periodontal (gum) treatment	_____
___	___	Bleeding gums	_____
___	___	Avoid brushing any part of your mouth	_____
___	___	Temporomandibular joint (TMJ – jaw) pain	_____
___	___	Clench or grind your teeth	_____
___	___	Jaw clicks or popping	_____
___	___	Tension Headaches	_____
___	___	Stiff neck muscles	_____
___	___	Difficulty chewing your food	_____
___	___	Difficulty opening your mouth widely	_____
___	___	Awaken with an awareness of your teeth or jaws	_____
___	___	Orthodontic (braces) treatment	_____
___	___	Do you gag easily?	_____
___	___	Do you have any oral habits? (Ice chewing, nail biting, thumb sucking?)	_____
___	___	Dry mouth, throat, and or eyes	_____
___	___	Difficulty swallowing	_____
___	___	A burning sensation in your mouth	_____
___	___	Have you ever noticed slow healing sores in or about your mouth?	_____
___	___	Do you take fluoride supplements?	_____
___	___	Are you unhappy with the appearance of your teeth?	_____
___	___	Do you like your smile?	_____

Do you have any dental disease, condition, or problem not previously listed, that you feel we should be aware of?

If so, please describe: _____

_____

Please do not write below this line, for office use only.

_____

_____

_____

DENTAL INSURANCE INFORMATION

Patients Name: _____ Date: _____

Subscriber (employee) Name: _____

Employee Date of Birth: _____

Social Security # or Insurance ID #: _____

Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Group or Policy #: _____

Phone Number: _____

Do you have a secondary insurance company? ☐ Yes ☐ No

Subscriber (employee) Name: _____

Employee Date of Birth: _____

Social Security # or Insurance ID #: _____

Employer: _____

Insurance Company Name: _____

Insurance Company Address: _____

Group or Policy #: _____

Phone Number: _____

REGARDING YOUR DENTAL BENEFITS.

Please understand that we file dental insurance as a courtesy to our patients. We do not have a contract with your insurance company. Dental insurance is a contract between you or your employer and a dental insurance company. The benefits you receive are based on the terms of the contract that was negotiated between you or your employer and the dental insurance company.

We encourage you to be familiar with your dental benefits.

- Preferred provider i.e.: in or out of network
- Benefit year – the month it begins and the month it ends
- Annual maximum
- Annual deductible
- Waiting period
- Payment level for: Preventive, basic, and major.
- Frequency of limitations for: exams, cleanings, x-rays, fillings and crowns (these are just a few of the most common types of treatment.

You may be able to access this information online through your insurance company, or they may provide you with a pamphlet.

We will send a preauthorization into your insurance company for treatment needed. Your insurance company will let you know your estimated benefits for the procedure(s) needed.

We are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim. You are responsible for any balance on your account after 45 days, whether insurance has paid or not.

MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

Signature Date

Acknowledgement of Receipt of Notice of Privacy Practices

McPhee Dental Group

* You May Refuse to Sign This Acknowledgment*

I have read/received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: _____

Date: _____

For Office Use Only

_____

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please Specify)

McPhee Dental Group ~ University Place, WA
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU: We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.
Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.
Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI. Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please Contact:
McPhee Dental Group
University Place, WA
253-565-4312

If we cannot resolve your complaint you have the right to file a complaint with the Secretary of the department of Health & Human Services (HHS) Office for Civil Rights, 2201 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will you be penalized for filing a complaint.