YAMAGUCHI
FAMILY DENTISTRY

PATIENT INFORMATION

First Name: ______ Last Name ______ Date of birth: ______ M ☐ F ☐

Home address: ______ City: ______ St: ______ Zip: ______

Billing address (if different): ______ City: ______ St: ______ Zip: ______

Home Phone: ______ Cell phone ______ Work phone: ______

Email: ______ Employer: ______

Primary insurance: ______ Subscriber's name: ______ DOB: ______

Group number: ______ ID / SS# ______

Secondary insurance: ______ Subscriber's name: ______ DOB: ______

Group number: ______ ID / SS# ______

DENTAL HEALTH HISTORY

Question	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have difficulty chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Do you avoid brushing any part of your mouth because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or about your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sweets?	☐	☐
Sours?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

How often do you brush? ______

How often do you floss? ______

Question	Yes	No
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning?	☐	☐
Does jaw pain or discomfort affect your appetite sleep, daily routine, or other activities?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort(pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Do you have pain in the face, cheeks, jaws, joints, throat, or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐

MEDICAL HEALTH HISTORY

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

	Yes	No
Heart Problems	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Pacemaker	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleed	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion?	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g., total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures, or Epilepsy	☐	☐
Stroke(s)	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely, to any of the following?	Yes	No
Local anesthetics ("Novocaine")	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen, or Ibuprofen	☐	☐
Codeine, Demerol, or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐

Other ____________

Notes ____________

	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ____		
Do you smoke?	☐	☐
If so, how much? ____		
Hepatitis, jaundice, or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive / AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition, or or problem not listed previously that you feel we should know about?	☐	☐

During the past 12 months, have you taken any of the following?	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase, or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

Other ____________

Women	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date:		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐

If so, do you have any symptoms? ____________

Do you have any disease, condition, or problem not listed previously that you feel we should know about? If so, please describe:

____

Signature ____________

Date ____________

FINANCIAL POLICY

Thank you for choosing us as your health care provider. We provide high quality dental services and products to our patients. We believe it is important that you be kept well informed. Good communication is essential to a healthy provider-patient relationship. It is our goal that you understand your treatment needs, as well as your financial responsibility before treatment begins.

The following financial policy will assist you in handling your account with us.

Please read this form carefully, initial and sign below. We are happy to answer any questions, please do not hesitate to ask.

INSURANCE	
We file insurance claims as a courtesy to our patients. All charges are your responsibility from the date services are rendered. Our office cannot guarantee the insurance payment as estimated.	Initials
Acceptance of Insurance: As dental care providers we must emphasize that our relationship is with you, not your insurance company. Your insurance is a contract between you, your employer and the insurance company. We are not a party to that contract except where we are preferred provider. Your plan benefits depend solely on what your employer wishes to offer you and your fellow employees. The extent of coverage has nothing to do with the level of service provided by our office and the fee charged for these services.	Initials
For your convenience, we will call your insurance company to verify patient eligibility as well as obtain an estimate of insurance coverage. **However, insurance plans vary greatly in the types of coverage they offer and we expect you to become familiar with your policy's benefits and limitations.** Furthermore, as your insurance company will inform you when you call, "benefits quoted are not a guarantee of payment as they are subject to current plan provisions or eligibility." You will be held financially responsible for services, which are not covered by your insurance plan.	Initials
Based on information provided by your insurance company, we will provide an estimate that will show expected insurance payment and estimated patient payment for each procedure. However, the estimated insurance payment should be considered a guideline until the final insurance payment is received and posted to your account. Please note that our fees may not correspondence with those of your insurance company. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates (UCR) and alternate benefit provisions. If you have questions regarding UCR, please ask.	Initials
FEES & PAYMENTS	
Due in full at the time of service. We accept cash, checks and major credit cards. **Returned Checks:** There will be a $25.00 handling charge for any returned checks.	Initials
The treatment fee is based on information gained from an examination of the patient and review of patient information. Should additional problems arise as treatment progresses, this estimated fee is subject to change. The patient will be informed of any increased fees and/or additional recommended treatment. Any treatment cost not covered by insurance will be due at the time of treatment.	Initials
Finance Charge: The total balance of account is subject to a 1% per month (18% APR) service charge after 60 days. If any installments are not paid when due, the whole, unpaid balance may, at our option, become immediately due.	Initials

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature of Patient or Responsible Party	Date
Printed Name	Responsible Party's Relationship to Patient

NOTICE OF PRIVACY PRACTICES

Protecting Your Confidential Health Information is Important to Us

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 (HIPPA) requires that all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose our health information.

Without specific written authorization, we are permitted to use and disclose your protected health information (PHI) for the purposes of providing your treatment, obtaining payment and conducting health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. This may include administrative and clinical office procedures designed to optimize scheduling and coordination of care within our office. In addition, we may share your health information with specialists, physicians, referring dentists, clinical and dental laboratories, pharmacies or other health care personnel providing your treatment.

- **Payment** means such activities as obtaining insurance reimbursement for services rendered, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information on an invoice used to collect payment for treatment you receive in our office, when billing your dental insurance for your dental services or determining the coverage allowed by your benefits plan.

- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for business planning and development that involves conducting cost-management and plan-related analysis related to managing and operating the entity, including formulary development and administration, necessary to facilitate needed care.

Unless you request otherwise, we may use or disclose your PHI to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care.

In addition, we may disclose your health information to insurance companies or government appointed agencies as part of their quality assurance and compliance care.

In addition, because we believe regular care is very important to your oral and general health, we may use your confidential information to remind you of scheduled appointments or that it is time for you to contact us and make an appointment by sending you reminder postcards, letters and/or leaving messages or voicemail at home and/or work. We may contact you to follow up on your care and inform you of treatment options or services that may be of interest to you or your family.

In addition, we may disclose your health information for public oversight activities, for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or report suspected abuse, neglect, or domestic violence.

Any other use and disclosure will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain used and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee will be assessed for duplication and assembly of your copy.
- The right to request an amendment to your protected health information. We may however, deny your request if the health information in question was not created by our office, is not part of our records or if the records containing your health information are determined to be accurate and complete.
- The right to receive and accounting of disclosures of protected health information make for any reason other than for treatment, payment, or health care operations. Our documentation procedures will enable us to provide information on health information usage from April 14, 2003 and forward.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice went into effect on April 14, 2003, 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. We are required to abide by the terms of the Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. To do so, please request a complaint form from our privacy director. We will not retaliate against you filing a complaint.

For more information about our Privacy Practices, please contact: Yamaguchi Family Dentistry
108 22nd Avenue SW, Suite 24
Olympia, WA 98501
(360) 943-9480

For more information about HIPAA or to file a complaint: US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
(877) 696-6775

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 (HIPPA). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up 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 *Notice 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 the above 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. I also 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.

ADDITIONAL DISCLOSURE AUTHORTY

In addition to the allowable disclosures described in the statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY member of my IMMEDIATE family	☐YES	☐NO
My SPOUSE only	☐YES	☐NO
OTHER, please specify:	☐YES	☐NO

Signature of Patient or Responsible Party	Date
Printed Name	Responsible Party's Relationship to Patient

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below

Initials: Date:

CANCELLATION POLICY

We ask for *at least* **48 hours advance notice (2 business days)** for canceling or rescheduling an appointment.

360-943-9480 ← Please take a moment to save our number.

All no-show or canceled appointments will be subject to a fee of $75.00.

This fee will be added to your account. Please note that *all cancellation fees must be paid prior to scheduling another appointment*.

Thank you for your consideration and we look forward to working with you!

I have read the Cancellation Policy. I understand and agree to this Cancellation Policy:

Signature of Patient or Responsible Party	Date
Printed Name	Responsible Party's Relationship to Patient