BURIEN DENTAL
EST. 1989

SMILE QUESTIONAIRRE

What is the most important thing to you about your teeth?

_____

_____

_____

What has been the nature of your past dental experiences?

_____

_____

_____

What is most important to you about the dental care you receive and the relationship with your care team?

_____

_____

_____

If you could rate your oral health on a scale of 1-10 (10 being the best), what would it be? . . . . . _____

What rating would you like to achieve? . . . . . _____

What do you feel you would need to reach your ideal smile?

_____

_____

_____

When there is something to be done, do you tend to wait until it must be done, or do you prefer to handle it before a crisis arises? _____

When we explain your treatment plan, do you prefer to receive the big picture, details, or a combination?

_____

What else would you like to share with your doctor regarding your care?

_____

_____

_____

_____

_____

_____

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PATIENT INFORMATION

Patient Name (as listed on insurance): _____

Social Security Number (only if needed for insurance): _____

Date of Birth: _____ **Preferred Name:** _____

Address: _____

Street *Unit/Apt#* *City* *State* *Zip*

Phone Numbers:

Cell _____ *Home* _____ *Work* _____

Email address: _____

Person Financially Responsible for this Account: _____

Parent Names (only if Patient is a minor): _____

Emergency Contact #1 Name: _____

Relationship to Patient: _____ Phone Number: _____

Emergency Contact #2 Name: _____

Relationship to Patient: _____ Phone Number: _____

PRIMARY INSURANCE INFORMATION

Employer (write "Individual" if coverage is not through an employer): _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Insurance Company: _____ **ID Number:** _____

SECONDARY INSURANCE INFORMATION

(If Applicable)

Employer (write "Individual" if coverage is not through an employer): _____

Subscriber Name: _____ **Subscriber Date of Birth:** _____

Insurance Company: _____ **ID Number:** _____

****I attest that this information is correct to the best of my knowledge. I agree to update the office of Dr. Everett and Dr. La Rota as soon as possible should any of this information change.****

_____ _____

Patient Signature Date

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OFFICE POLICIES: Financial Policy

We have established our Financial Policy in the interest of good communication and our continued commitment to provide high quality dental care to all of our patients. It is our wish that this policy will facilitate open communication between use and help avoid potential misunderstandings, allowing you to make the best choices related to your care.

In our commitment to support you in understanding your dental health, we will present you with the best dental solutions to treat your personal situation. To make these services comfortably affordable we are pleased to offer a variety of payment options.

Please discuss your questions and concerns regarding these policies with any member of our front desk staff to ensure you have an outstanding experience.

Carefully review and acknowledge the policies listed below. Please note that if you do not agree to any of the following policies, our office will not be the correct fit for you and we will be unable to treat you in our office.

- I understand all questions regarding my insurance benefits or payments must be addressed to my insurance carrier.
- I understand that I am fully responsible for the total payment of all procedures in this office, including any treatment rendered that is not covered by my insurance policy.
- I understand that any estimated portion presented to me is due at the time of service.
- I understand that all treatment plans presented to me in office are only an estimate and not a guarantee of payment.
- I understand all balances are due within 90 days of date of service, whether my insurance benefits have been received or not.
- I understand that Washington state allows 0.75% interest to be charged per month to any balance remaining that is due over 90 days for a total of nine percent (9%) interest per year.
- I understand that if I wish to make payments on a service rather than paying my full fee on service date, I may only do so through Sunbit or CareCredit, and that the office does not execute payment plans of any kind in-office.
- I authorize the provider to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf.
- I personally will be active in the resolution of any claims delay or unjustified reductions or denials.

I have been given the opportunity to ask questions regarding this document and have received satisfactory answers. I have read, understood and agree to all statements put forth in this document.

_____ _____

Patient Name (Printed) Guardian Name (Printed, if applicable)

_____ _____

Patient or Guardian Signature Date

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OFFICE POLICIES: Cancellation Policy

We take your care with the utmost importance and painstakingly reserve the necessary time for each of our patients. We set aside these appointments to provide you with quality care, and we encourage our patients to prioritize their care as well.

While we do understand that circumstances arise that are out of anyone's control, we hope you will be an active participant in your care at our office and that you will make your best efforts to attend your appointments. Our office does not bill any cancellation fees at this time as we do not want to penalize you for unexpected events. With this acknowledgement, we do also want you to be aware that if a pattern is established, our ability to reserve your appointment times will change.

Carefully review and acknowledge the policies listed below. Please note that if you do not agree to any of the following policies, our office will not be the correct fit for you and we will be unable to treat you in our office.

- I understand I will receive multiple forms or communication to confirm my appointment, including text, email, and phone call depending on the information I have provided and my communication preferences.
- I understand that each appointment must be confirmed as soon as possible to complete my reservation.
- I understand that if my confirmation is not received within 48 business hours of my appointment, it will be released, and I will no longer have that time reserved.
- I understand that if I establish a pattern of cancelling within 48 business hours or less or no-showing my appointments I will be placed on a same-day schedule only status at the discretion of Dr. Everett.
- I understand that if I am placed on same-day schedule only status, I must call on days I am available to see if the office has an opportunity to see me for my desired appointment and that I will not be able to pre-book any appointments.

I have been given the opportunity to ask questions regarding this document and have received satisfactory answers. I have read, understood and agree to all statements put forth in this document.

_____ _____

Patient Name (Printed) Guardian Name (Printed, if applicable)

_____ _____

Patient or Guardian Signature Date

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HIPAA: 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 in our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that may affect your rights and preferences.

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 Washington state. This includes issues related 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 may give written authorization for us to disclose your information to anyone you choose for any purpose. Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current and future patients. You can be confident that your protected health information will never be improperly disclosed or released.

Collecting Your Protected Health Information (PHI)

We will only request personal information needed to provide our standard quality of 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 (PHI)

We may disclose information as required by law. We are obligated to provide information to law enforcement and government officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail or text messages. 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 Rule. You have the right to and will be provided all information relating to any breach involving your personal PHI.

Your Rights as Our Patient

You have the right to request copies of your healthcare information in a variety of formats and to request a list of instances in which we or our 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 US Department of Health and Human Services. Please ask if you have any questions about your privacy rights or the protection of your health information.

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HIPAA: 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 Dr. Jonathan Everett. 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 performances of office healthcare operations. The Statement of Privacy practices also describes my rights and the responsibilities of this office with respect to my protected health information.

I understand that Dr. Everett 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 Policies by requesting one be mailed or e-mailed to me, or by accessing my online Patient Portal.

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 without indicating "YES" and writing in the name(s) of those allowed my PHI cannot will be shared with anyone unless otherwise allowed by HIPAA rules.

Allow Other Person(s) Access to my PHI:

- □ YES: (Please List by Name) :
  _____
  _____
  _____
- □ NO (Except to Offices Dr. Everett or Dr. La Rota have referred me to for continuing care)
- □ NO (to all)

_____ _____

Patient Name (Printed) Guardian Name (Printed, if applicable)

_____ _____

Patient or Guardian Signature Date

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HEALTH HISTORY

We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. These details are important to your dental health. If there have been any changes in your health, please tell us. If you have questions, please ask the front desk or your care team

_____ _____

Primary Care Physician Name and Location Date of last visit

☐ Have you been advised by your physician / doctor that you are required (or strongly recommended) to take a pre-medication prior to your dental appointments? If so, what type of medication?_____

Do you have or have you ever had any of the following? Please check all that apply.

☐ AIDS/HIV Positive	☐Cortisone Medicine	☐Heart Trouble/Disease	☐Renal Disease
☐ Alzheimer's Disease	☐Depression	☐Hemophilia	☐Renal Dialysis
☐ Anaphylaxis	☐Diabetes	☐Hepatitis A	☐Rheumatic Fever
☐Anemia	☐Drug Addiction	☐Hepatitis B or C	☐Rheumatism
☐Anxiety	☐Easily Winded	☐Herpes	☐Scarlet Fever
☐Arthritis/Gout	☐Emphysema	☐High Blood Pressure	☐Shingles
☐Artificial Heart Valve	☐Epilepsy or Seizures	☐Hives or Rash	☐Sickle Cell Disease
☐Artificial Joint	☐Excessive Bleeding	☐Hypoglycemia	☐Sinus Trouble
☐Asthma	☐Excessive Thirst	☐Irregular Heartbeat	☐Spina Bifida
☐Blood Disease	☐Fainting Spells/Dizziness	☐Kidney Problems	☐Stomach/Intestinal Disease
☐Blood Transfusion	☐Frequent Cough	☐Leukemia	☐Stroke
☐Breathing Problem	☐Frequent Diarrhea	☐Liver Disease	☐Swelling of Limbs
☐Bruise Easily	☐Frequent Headaches	☐Low Blood Pressure	☐Thyroid Disease
☐Cancer	☐Genital Herpes	☐Lung Disease	☐Tonsilitis
☐Chemotherapy	☐Glaucoma	☐Mitral Valve Prolapse	☐Tuberculosis
☐Chest Pains	☐Hay Fever	☐Pain in Jaw Joints	☐Tumors or Growths
☐Cold Sores/Fever Blisters	☐Heart Attack/Failure	☐Parathyroid Disease	☐Ulcers
☐Congenital Heart Disorder	☐Heart Murmur	☐Radiation Treatments	☐Venereal Disease
☐Convulsions	☐Heart Pacemaker	☐Recent Weight Loss	☐Yellow Jaundice

Women only, are you currently: ☐ Pregnant ☐Taking oral Contraceptives ☐ Trying to get pregnant? ☐Nursing?	**Men only**, do you have or have you had: ☐Prostate Disorder

CHECK IF YOU ARE ALLERGIC TO ANY OF THE FOLLOWING (i.e. itching, rash, swelling of hands/feet):

☐ Aspirin	☐Fluoride	☐Penicillin/Amoxicillin	☐Latex
☐ Codeine	☐Metals	☐Erythromycin	☐Dental Anesthetic

Please list any other drugs/ materials that you are allergic to:

_____

_____

Current Medications:

Name	Dosage	Reason for Taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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Please mark any questions you would answer "YES"

- ☐ Are you apprehensive about dental treatment?
- ☐ Does food catch between your teeth?
- ☐ Do you have difficulty chewing your food?
- ☐ Does it hurt when you chew or open wide to take a bite?
- ☐ Do you have an uncomfortable bite when chewing or resting your teeth together?
- ☐ Are you unable to open your mouth as far as you want?
- ☐ Do you gag easily?
- ☐ Are your teeth sensitive?

Do you feel twinges of pain when your teeth come into contact with:

☐ Hot ☐ Cold ☐ Sweet ☐ Sour

- ☐ Do you avoid brushing your teeth because of pain?
- ☐ Do your gums bleed easily when brushing or flossing?
- ☐ Do your gums feel tender or swollen?
- ☐ Have you ever noticed slow-healing sores in or around your mouth?
- ☐ Do you take fluoride supplements?
- ☐ Do you wear dentures?
- ☐ Do you use snore when sleeping?
- ☐ Have you been diagnosed with sleep apnea?
- ☐ Do you use a device for sleep apnea?
- ☐ Do you have temporomandibular disorder (TMJ, TMD)?
- ☐ Do you clench or grind your jaws frequently?
- ☐ Do your jaws ever feel tired?
- ☐ Do you have earaches or pain in front of the ears?
- ☐ Do you have pain in the face, cheeks, jaws, joints, throat or temples?
- ☐ Do you have any jaw symptoms or headaches upon waking in the morning?
- ☐ Does jaw pain or discomfort affect your appetite, sleep, or daily routine?
- ☐ Do you find jaw pain or discomfort extremely frustrating or depressing?
- ☐ Are you a habitual gum-chewer or pipe smoker?
- ☐ Have you had a trauma or blow to your jaw?

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

_____

_____

_____

_____

_____

STATEMENT OF ACKNOWLEDGEMENT

Dental diseases are caused by a combination of factors, some more complex than others. Definitive treatment is prescribed to control specific etiological factors present in each particular case.

The success of dental treatment is dependent on many factors including periodontal integrity, the patient's general health and the patient's ability and willingness to perform proper oral hygiene in and out of the office on a regular basis. As with treatment of any disease, no cure can be guaranteed or unsuspected problems can arise.

We will make every effort to fully inform you of the treatment diagnosed for you. Please direct your questions to any staff member at any point in your care. Your involvement and understanding are vital to the long term success of your treatment.

INFORM THE DOCTOR OR ANOTHER MEMBER OF YOUR CARE TEAM IF YOUR HEALTH CHANGES IN ANY WAY.

I, the undersigned (patient or legally responsible party), authorize dental treatment to be rendered by the Dentist and his Staff, and assume financial responsibility. I have reviewed my medical and dental history, as well as the statement of acknowledgement, and have updated any changes.

_____ _____

Patient Name (Printed) Guardian Name (Printed, if applicable)

_____ _____

Patient or Guardian Signature Date