PATIENT REGISTRATION

Welcome and thank you for choosing our practice for your dental care. Please take a few minutes to complete this form to the best of your ability. The information you provide is essential in ensuring that you receive the best dental care possible. Any items about which you are uncertain, please leave blank and bring to our attention. We look forward to working with you in maintaining your oral health. Please complete all pages and don't forget to sign and date!

Patient Information

Date _____ Cell Phone (___) _____

Home Phone (___) _____

Patient Name: _____

Last Name First Name Initial Preferred

Street Address _____ City _____ State _____ Zip _____

Email Address _____

Gender: F / M / Other Date of Birth _____ Soc. Sec. #_____

Occupation _____ Work Phone (___) _____

In case of emergency, who should we notify? _____ (___) _____

Name Phone Number

If you are not receiving treatment today, what is your relationship to the patient? _____

Whom may we thank for referring you? _____

Insurance Information

☐ No insurance at this time

Primary Dental Insurance

Please provide your insurance card so a copy can be made for our records

Name of Primary Subscriber: _____

Last Name First Name Initial

Relation to Patient _____ Date of Birth _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State _____ Zip _____ Phone (___) _____

Employer of Primary Subscriber: _____

Business Address _____

Street City State Zip

Business Phone (___) _____ Insurance Company _____

Group # _____ Subscriber ID#_____

Names of other dependents covered under this plan_____

Additional Dental Insurance

Is patient covered by any additional dental insurance ? ☐ Yes ☐ No

Subscriber name _____ Date of birth _____

Relation to patient _____ Soc. Sec. # _____

Address (if different from patient's) _____

City _____ State _____ Zip _____ Phone (___) _____

Subscriber Employed by _____ Business Phone (___) _____

Insurance Company _____

Group # _____ Subscriber #_____

Names of other dependents covered under this plan_____

MEDICAL HISTORY

Physician's name _____ Phone (___) _____

Last seen approximately _____ Reason for visit _____

Month Year

Are you under the care of a physician? ☐ Yes ☐ No If yes, for what condition(s)? _____

_____

Please list all medications you are currently taking (Please include all prescription medication, over the counter medication, herbal remedies and vitamins)_____

_____

Please list any drug/medication allergies _____

_____

Have you had any serious illness in the last five years? ☐ Yes ☐ No

If yes, please describe _____

Have you had any operations in the last five years? ☐ Yes ☐ No

If yes, please describe _____

Have you ever responded adversely to medical or dental treatment? ☐ Yes ☐ No

If yes, please describe _____

Have you experienced any major life changes or stressful events in the previous 12 months? ☐ Yes ☐ No

Have you ever had any of the following? (check all that apply)

☐ Heart problem	☐ Persistent cough	☐ Cough up blood
☐ Pacemaker	☐ Tuberculosis	☐ Mental health disorder
☐ Mitral valve prolapse	☐ Respiratory disease	☐ Chemical dependency
☐ Rheumatic fever	☐ Asthma	☐ Fainting
☐ Congenital heart lesions	☐ Shortness of breath	☐ Thyroid Problems
☐ Pace maker	☐ Cancer	☐ Diabetes
☐ Circulatory problems	☐ Chemotherapy	☐ Arthritis
☐ Artificial heart valves	☐ Radiation to head or neck	☐ HIV/ AIDS
☐ Artificial Joints	☐ Jaundice or liver disease	☐ Immunosuppressive disorder
☐ High blood pressure	☐ Hepatitis (Type __)	☐ Gastrointestinal disorder
☐ Low blood pressure	☐ Kidney disease	☐ Sexual transmitted disease
☐ Hemophilia	☐ Dialysis	☐ Sinus Problems
☐ Anemia	☐ Stroke	☐ Bone disorder
☐ Blood disease	☐ Nervous system problems	☐ Drastic weight loss
☐ Excessive bleeding	☐ Epilepsy	☐ Back problems
☐ Headaches	☐ Developmental disorder ---->	☐ (Type _____)

Please list any other medical conditions or illnesses you may have that where not listed above: _____

_____

_____

Do you use tobacco products? ☐ Yes ☐ No If yes, what type of product do you use? _____

How often do you use product?_____ How much do you use? _____

Have you had **IV bisphosphonate** (eg. Aredia or Zometa) therapy? ☐ Yes ☐ No

Have you ever taken **oral bisphosphonate** (eg. Actonel, Boniva, Fosamax, Skelif, or Didronel) therapy?

☐ Yes ☐ No Women Only: Are you pregnant? ☐ Yes ☐ No ☐ Maybe Are you nursing? ☐ Yes ☐ No

Are currently using birth control? ☐ Yes ☐ No

Is there anything else in your medical history we should know about? _____

_____

Dental History

Reason for today's visit: _____

Date of last dental care _____ Date of last dental x-ray _____
Month Year Month Year

Have you experienced any of these problems? (check all that apply)

☐ Bleeding/Sensitive gums	☐ Missing Teeth	☐ Oral Abscess
☐ Periodontal treatment	☐ Grinding/ clenching of teeth	☐ Blisters
☐ Infection in gums	☐ Broken fillings	☐ Chew on one side
☐ Jaw pain/ TMJ	☐ Sensitivity to cold	☐ Difficulty chewing
☐ Pain around ears	☐ Sensitivity when biting	☐ Dry mouth
☐ Stained Teeth	☐ Sores or growths in your mouth	☐ Gag easily

List any dental problems you have experienced that are not listed: _____

_____

How often do you floss? _____ How often do you brush? _____

Have you ever felt anxious about receiving dental treatment? ☐ Yes ☐ No

Please let us know if you have any special areas of concern: _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT

Whole Earth Dental
Eran J. Gutkin, DMD
3203 West McGraw Street Suite 201
Seattle, WA 98199
206.283.0964

Patient's Name: _____ Date of Birth: _____

I understand that, under the Health Insurance Portability Accountability Act (HIPAA) of 1996, I have certain rights to privacy in regards to my protected health insurance (PHI). I have received, read and understood the Notice of Privacy Practice.

The practice reserves the right to change the terms of its Notice of Privacy Practice. I understand the Practice will provide current Notice of Privacy Practice on request.

Patient Signature: _____ Date: _____

Representative/Custodian: _____
(Name)

Representative/Custodian: _____ Date: _____
(Signature)

Relationship to Patient: _____

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is available in the office upon request.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. http://www.hhs.gov/

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, text message, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____date_____do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

FINANCIAL AGREEMENT & POLICIES
For The Office Of Dr Eran Gutkin, DMD, PS

☐This agreement is to inform you of the financial responsibility to our practice for treatment you receive. We are committed to providing you with the most comprehensive dental care to the highest clinical standards and using the highest quality materials available. **All charges you incur for any treatment provided are ultimately your responsibility**. Treatment is always recommended based upon your dental needs not insurance coverage. Dental insurance is designed to assist you in regular maintenance, not to dictate necessary treatment.

☐**Unless other financial arrangements have been previously made, Payment is expected at time of service.** Payment is accepted in cash, personal checks, debit, Visa, and Mastercards. Third party extended payment financing (Care Credit) is also available upon request and approval. Only uninsured, cash paying patients may be entitled to time-of-service or senior discounts. Treatment covered by dental insurance is heavily discounted from usual and customary fees and not subject to additional discounts.

☐As we work together to reach optimum oral health, we require the Estimated Patient Portion (or co-payment/deductible) for treatment be paid at the time of service. The Estimated Patient Portion is the portion of our fee you have agreed to pay based upon the level of coverage you (and/or your employer) have agreed to with the insurance company. This portion can range from 0% to 100% of the fee in question.

☐Estimated Patient Portion may need to be adjusted after time of treatment if circumstances change the final reconciliation of insurance payments. Such circumstances may include: exceeding remaining yearly insurance maximum, clinical findings necessitating a change in treatment plan, previous treatment history negating coverage for a particular procedure, or additional payment from secondary insurance, etc.

☐Our practice will accept payment from your insurance company. The agreement regarding your dental benefits is between you, your employer, and your insurance company. Although we submit dental claims on your behalf, we do not accept responsibility for the outcome of the transaction. We strongly advise you, as our patient, to familiarize yourself with your coverage and your benefits.

☐Submitting insurance claims on your behalf is a courtesy our practice extends to you at no charge in an effort to save you time and expedite payment from the insurance company. A denied insurance claim does not negate the clinical necessity of treatment, nor eliminate financial obligation for services already rendered. The practice cannot guarantee that your insurance company will assist you with payment for the treatment you receive. If a claim is denied, you will be responsible for paying the full amount. Our practice will not enter into a dispute with your insurance company over any claim, although we will provide all available documentation your insurance company requests including resubmitting a claim if necessary. You may request a Predetermination be sent to investigate potential coverage; however, because they are not a guarantee of coverage, Predeterminations are not a routine part of the claims process.

☐Patient overpayment resulting in a positive balance will be left as a credit on the patient's ledger unless a refund is otherwise requested.

☐Should you choose or need to leave the practice, your balance must be paid in full before any records can be transferred and a release of records placed on file.

I HAVE READ AND ACCEPT THE TERMS AND CONDITIONS OF THE FINANCIAL AGREEMENT. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO THE PRACTICE.

_____
Print Name of Patient or Responsible Party

_____ _____
Signature of Patient or Responsible Party Date Date

WHOLE EARTH DENTAL

Broken Appointment Policy
Whole Earth Dental
Eran Gutkin, DMD P.S.

- ✔ Our practice requires 48 business hours notice to cancel/reschedule an existing appointment.
- ✔ We reserve the right to charge a $75 Broken Appointment Fee per scheduled hour canceled or failed without a 48 hour notice.
- ✔ Your appointment time has been reserved and set aside for your treatment and care, and cannot be easily offered to another patient on short notice.
- ✔ Failing to give notice for a missed appointment denies other patients in need of treatment the opportunity to schedule at that time.
- ✔ Like all other charges, Broken Appointment Fees for minors are the financial responsibility of their parental/legal guardians.
- ✔ Appointments missed or canceled due to unforeseen circumstances will be considered on a case by case basis.

Signature_____ Date_____