



PATIENT RECORD

DATE: _____

NAME: _____ SOC. SEC. #: _____

ADDRESS: _____ DATE OF BIRTH: _____

CITY: _____ STATE: _____ ZIP: _____

PHONE (H): _____ CELL: _____ EMAIL: _____

EMERGENCY CONTACT: _____ PHONE #: _____

DENTAL INSURANCE CARRIER: _____ ID#: _____

NAME OF SUBSCRIBER: _____ SUBSCRIBER DOB: _____

OTHER DENTAL INSURANCE: _____

DENTIST: _____ PHYSICIAN: _____

PRIVACY PRACTICES

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

- Provide and coordinate my treatment 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 Notices 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 this 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 and I 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.

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we request payment at the time services are rendered. For your convenience we will accept Cash, Check, Visa, MasterCard, American Express, Discover or Care Credit. If you have dental insurance, please be sure our office has your current dental insurance information at the time of your initial visit. We will gladly assist you in completing and submitting your claim. Please know not all services are covered by insurance companies (e.g. *Gentle Wave Technology*, CBCT Scans). When signing below you are allowing Skagit Endodontics to collect billed charges for services denied as “non-covered” by your insurance company.

FINANCIAL ARRANGEMENTS

Please circle the option you prefer for today’s visit.

Cash or Check	MasterCard
Discover	Care Credit
American Express	Visa

FINANCIAL AGREEMENT, AUTHORIZATION AND RELEASE:

I authorize the doctor to release any examination, diagnosis or treatment information regarding me or my dependent to third party payers and/or health practitioners. I understand that my insurance carrier may pay less than the actual fee for services. I agree to be responsible for payment of all services rendered on my behalf or on my dependents. If this account is not paid in full at time of service, a service charge of 1.5% per month, which is 18% per annum, will be charged on all balances of 30 days or greater. A minimum \$5 late charge will be assessed on your account. If this account is not paid as agreed, and legal action is commenced to collect the amount due, I/we agree that in addition to the other charge herein, I/we will pay reasonable attorney fees. At the request of either party, venue for any legal action shall be placed in Skagit County, WA.

I certify that I have read and understand the above

Privacy Practices and Financial Policy Statement and to the best of my knowledge all medical History questions have been accurately answered.

Date: _____

Signature: _____

Signature of Patient (or Parent, if patient is a minor)

PATIENT MEDICAL HISTORY

Date: _____

Has there been any change in your general health within the last 2 years? YES NO

If yes, please specify _____

Are you currently taking any medications? (Including non-prescription medications.) YES NO

If yes, please specify or provide list. _____

Have you ever been treated for Infective Endocarditis (infection of the heart lining)? YES NO

Have you received therapy for alcoholism or drug addiction within the last five years? YES NO

If yes, please specify. _____

Have you ever had any allergic or adverse reactions to Latex, anesthetics, antibiotics, or other medications or substances? YES NO If yes, please specify below: _____

Are you currently taking or have you taken bisphosphates or anti-resorptive medications for bone density or cancer treatment? (E.g. Fosamax, Actonel, Zometa, Aredia, Boniva, Denosumab). YES NO

If yes, when? _____

Are you required to pre-medicate with antibiotics prior to dental procedures? YES NO

If yes, for what condition and when e.g. artificial joint, heart valve, MVP. _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS: (please circle all that apply)

- | | | | |
|------------------------|---------------------------|------------------------------|---------------------------------|
| Heart disease | Excessive Bleeding | Osteoporosis | Angina Pectoris |
| Cancer / Tumor | Hepatitis A or E | Hepatitis B or C | HIV / AIDS |
| Radiation | Heart Murmur | Emphysema | Liver Disease |
| Rheumatic Fever | Tuberculosis (TB) | Blood Transfusion | Congenital Heart Defect |
| Asthma / COPD | Prosthetic Heart valve | Sinus Trouble | Hemophilia |
| Cardiac Pacemaker | Allergies or Hives | Epilepsy or Seizures | Heart Surgery |
| Diabetes | Fainting or Dizziness | Artificial Joint | Thyroid Disease |
| Nervousness | Anemia | Chemotherapy | Psychiatric Treatment |
| Stroke | Bruise easily | Kidney/ Renal Disease | Glaucoma |
| Heart failure | Ulcers | TMJ | Heart Attack |
| Infective Endocarditis | High / Low Blood Pressure | Sexually Transmitted Disease | Cortisone (Steroid) Medications |

WOMEN ONLY:

Are you pregnant or think you may be pregnant? YES NO

Are you nursing? YES NO

Are you taking oral contraceptives? YES NO

If yes, please be advised that if you take antibiotics, an alternate method of birth control must be used