

PATIENT REGISTRATION

PATIENT INFORMATION

Patient Name

Spouse (Parent's names if patient is a minor)

Address

City State Zip

Home phone Work phone

Cell phone

Birthdate Male Female

Occupation

If college student – name of school

ACCOUNT INFORMATION

Person financially responsible for account

Relationship to patient

Address

City State Zip

Home phone Work phone

Cell phone

IN CASE OF EMERGENCY – PLEASE CONTACT

Name Phone

I WAS REFERRED TO YOUR OFFICE BY _____

DENTAL INSURANCE - PRIMARY INS

Insurance Company Name

Employer Group or Policy #

Address

City State Zip

Phone

Subscriber of insurance

Subscriber birthdate Social Security # or Insurance ID #

DENTAL INSURANCE - SECONDARY INS

Insurance Company Name

Employer Group or Policy #

Address

City State Zip

Phone

Subscriber

Subscriber birthdate Social Security # or Insurance ID #

DENTAL HISTORY

Patient Name _____

1. What is the reason for your visit today? _____
2. Date of last dental visit _____ last dental cleaning _____ last xrays _____
3. What was done at your last dental visit? _____
4. Previous dentist's name _____
 Address _____ City _____ State _____
 Telephone _____
5. How often do you have dental examinations? _____
6. How often do you brush your teeth? _____ How often do you floss? _____
7. What other dental aids do you use? (sonicare, toothpick, rubber tip, etc.) _____
8. Do you have any dental problems now? Yes No
 If yes, please describe _____

<p>Are any of your teeth sensitive to:</p> <p>Yes No Hot or cold</p> <p>Yes No Sweets</p> <p>Yes No Biting or chewing</p> <p>Yes No Have you noticed any mouth odors or bad tastes?</p> <p>Yes No Do you frequently get cold sores, blisters or any other oral lesions?</p>	<p>Have you ever had:</p> <p>Yes No Orthodontic treatment</p> <p>Yes No Oral surgery</p> <p>Yes No Periodontal treatment</p> <p>Yes No Your teeth ground or the bite adjusted</p> <p>Yes No A bite plate or mouthguard</p> <p>Yes No A serious injury to the mouth or head</p> <p>If so, please describe, including cause _____</p>
<p>Yes No Do your gums bleed or hurt?</p> <p>Yes No Have your parents experienced gum disease or tooth loss?</p> <p>Yes No Have you noticed any loose teeth or change in your bite?</p> <p>Yes No Does food tend to become caught in between your teeth?</p> <p>If yes, where? _____</p>	<p>Have you experienced:</p> <p>Yes No Clicking or popping of the jaw</p> <p>Yes No Pain in jaw joint, ear or side of face</p> <p>Yes No Difficulty in opening or closing mouth</p> <p>Yes No Difficulty in chewing on either side of mouth</p> <p>Yes No Headaches, neckaches or shoulder aches</p> <p>Yes No Sore muscles in neck or shoulders</p>
<p>Do you:</p> <p>Yes No Clench or grind your teeth while awake or asleep</p> <p>Yes No Bite your lips or cheeks regularly</p> <p>Yes No Hold foreign objects with your teeth such as pencils, pins, nails, pipe, fingernails</p> <p>Yes No Mouth breathe while awake or asleep</p> <p>Yes No Have tired jaws, especially in the morning</p> <p>Yes No Smoke or chew tobacco</p>	<p>Yes No Are you satisfied with your teeth's appearance?</p> <p>Yes No Would you like to keep all of your teeth all of your life?</p> <p>Yes No Do you feel nervous about having dental treatment?</p> <p>If so, what is your biggest concern? _____</p> <p>Yes No Do you use nitrous oxide (laughing gas) for dental treatment?</p> <p>Yes No Have you ever had an upsetting dental experience?</p> <p>If yes, please describe _____</p>

If there is anything else about having dental treatment that you would like us to know, please describe:

Patient/Guardian Signature _____ Date _____

MEDICAL HISTORY

Patient Name _____

1. Have you been under the care of a medical doctor during the past two years?..... Yes No
 If yes, for what? _____
 Physician's Name _____ Phone _____
 Address _____ City _____ State _____
2. Have you taken any medication or drugs during the past two years? _____ Yes No
3. Are you taking any medication, drugs or pills now? _____ Yes No
 If yes, please list name and dosage _____
4. Are you taking any medication for osteoporosis? _____ Yes No
5. Are you aware of having an **allergic or adverse reaction** to any medication or substance? Yes No
 If yes, please list _____
6. Have you been a patient in the hospital during the past five years? _____ Yes No
7. Indicate which of the following you have had, or have at present. Circle "Yes" or "No" to each.

Yes No Heart disease, or heart attack	Yes No Ulcers	Yes No Hepatitis A (infectious) or B (serum)
Yes No Chest pain	Yes No Diabetes	Yes No Venereal disease
Yes No Congenital heart disease	Yes No Thyroid problems	Yes No AIDS
Yes No Heart murmur	Yes No Glaucoma	Yes No HIV positive
Yes No High blood pressure	Yes No Contact lenses	Yes No Cold sores/fever blisters
Yes No Mitral valve prolapse	Yes No Emphysema	Yes No Blood transfusion
Yes No Artificial heart valve	Yes No Chronic cough	Yes No Hemophilia
Yes No Heart pacemaker	Yes No Tuberculosis	Yes No Sickle cell disease
Yes No Rheumatic fever	Yes No Asthma	Yes No Bruise easily
Yes No Arthritis/rheumatism	Yes No Hay fever	Yes No Liver disease
Yes No Cortisone medicine	Yes No Latex sensitivity	Yes No Yellow jaundice
Yes No Swollen ankles	Yes No Allergies/hives	Yes No Neurological disorders
Yes No Stroke	Yes No Sinus trouble	Yes No Epilepsy/seizures
Yes No Diet (special/restricted)	Yes No Radiation therapy	Yes No Fainting or dizzy spells
Yes No Artificial joints (hip/knee/etc)	Yes No Chemotherapy	Yes No Nervous/anxious
Yes No Kidney problems	Yes No Tumors	Yes No Psychiatric/psychological

8. Do you have sleep apnea? Do you snore or use a snoreguard? Yes No
9. Have you lost or gained more than 10 pounds in the past year? Yes No
10. Do you have or have you had any disease, condition, or problem not listed? Yes No
 If yes, please list _____
11. **WOMEN:** Are you: **Pregnant?** Yes ___ months No **Nursing?** Yes No **Taking birth control pills?** Yes No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medication.

Patient/Guardian Signature _____ Date _____

RONALD E. FROST, D.D.S., P.S.

16701 Cleveland Street #200
Redmond, WA 98052
425-883-4099

CONSENT FOR TREATMENT

Patient Name _____

I hereby authorize Dr. Frost or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my or my dependent's needs.

Upon such diagnosis, I authorize Dr. Frost and the dental staff under his direction to perform the necessary dental services my child or I may need.

I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete explanation of any possible complications.

Patient's Signature (18 or older) _____

Date _____

Parent/Guardian's Signature _____

Date _____

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FINANCIAL AGREEMENT

It is our policy for patients to clearly understand their treatment needs, as well as their financial responsibility. We desire to make dental treatment affordable to all of our patients. Therefore we offer the following financial arrangements.

1. PATIENTS WITH INSURANCE – Estimated portion not covered by insurance is due at time of treatment. We will gladly submit claims to the carrier but understand the contract is between yourself and the insurance company and it is your responsibility to monitor your coverage and benefits.
2. PATIENTS WITHOUT INSURANCE – Payment is due in full at the time of treatment.
3. VISA or MASTERCARD
4. PATIENT FINANCING – We can provide a limited amount of credit to qualified patients for a maximum term of 60 days at a finance charge rate of 18% APR. We are pleased to offer a payment plan through the Dental Fee Plan administered by Capital One. See our financial coordinator if you are interested in this option.
5. LATE CHARGE of 1.5% (18% APR) will be applied on all unpaid account balances after 30 days.
6. RETURN CHECK FEE of \$25.00 will be applied to accounts when a check is returned from the bank unpaid.
7. Treatment that requires dental laboratory services will require a lab deposit at the initial appointment of that treatment.
8. The person bringing a child in for treatment will be considered the responsible party and will be billed as such. Our office will not bill any other party.

I have read and understand the above financial policies. **Regardless of insurance coverage**, I am responsible for payment of all dental fees for myself and/or my dependents. I authorize Dr. Frost to furnish information to insurance carriers concerning my and/or my dependents dental treatment. I hereby assign to the dentist, all payments for dental services rendered.

Signature _____ Date _____

RONALD E. FROST, D.D.S., P.S.

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Redmond, WA 98052

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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 principle concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

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 the state of Washington. This includes issues relating 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, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices 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, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTION PROTECTED HEALTH INFORMATION

We will only request personal information needed to provide our standard of quality health 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

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental 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 messages, answering machines, and postcards.

PATIENT RIGHTS

You have the right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business 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 U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

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**ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT
OF PRIVACY PRACTICES**

I acknowledge that I have read and/or received a copy of the Statement of Privacy Practices for the offices of Ronald E. Frost, DDS. This statement describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. This statement also describes my rights and the responsibilities and duties of this office with respect to my protected health information. This statement is also posted in the facility.

Ronald E. Frost, DDS reserves the right to change the privacy practices that are described. If privacy practices change, I will be offered a copy of the revised statement at the time of my first visit after the revisions become effective.

ADDITIONAL DISCLOSURE AUTHORITY

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___
SPOUSE ONLY Yes___ No___
OTHER (please specify) Yes___ No___

Name of Patient

Signature of Patient or
Guardian/Representative

Date

Office Use Below This Line

Reason for Denial: ___ Needs more time to review statement
 ___ Wanted to consult with another person first
 ___ Reason not given
 ___ Other (explain)