Issaquah Dental Arts
Merkel & Hansen, PLLC
PATIENT REGISTRATION WORKSHEET

Patient Information

Name: _____ Birthday: _____ ☐Male ☐Female SS#:_____

Home Address: (Street)_____(City)_____(State)_____(ZIP)_____

Home Tel#:(_____)_____ Work Tel#:(_____)_____

Employer: _____ E-mail _____

Work Address: (Street)_____(City)_____(State)_____(ZIP)_____

Name of Previous Dentist: _____ City:_____ State:_____

Guarantor Information (person completing this form for minors or those under custodial care)

Name: _____ Birthday: _____ ☐ Male ☐ Female SS#:_____

Home Address: (Street)_____(City)_____(State)_____(ZIP)_____

Home Tel#:(_____)_____ Work Tel#:(_____)_____

Employer: _____ E-mail (optional)_____

Insurance Information

Primary Dental Insurance
Insurance Name_____

Employer: _____ Group Number:_____

Subscriber:_____ Birthday:_____

Subscriber SS#: _____

Secondary Dental Insurance
Insurance Name_____

Employer:_____Group Number:_____

Subscriber:_____ Birthday:_____

Subscriber SS#: _____

Emergency Contact (Please list one relative or friend not living with you.)

Name: _____

Home #: _____Work #:_____

Home Address: (Street)_____

(City)_____(State)_____(ZIP)_____

Name: _____

Home #: _____Work #:_____

Home Address: (Street) _____

(City)_____(State)_____(ZIP)_____

Contract to Pay for Medical Services
In consideration of the required professional services provided to the above patient, I/we agree to pay the account for these services in full, at the time of service, unless other arrangements have been made with Issaquah Dental Arts. I/we authorize Issaquah Dental Arts to receive assignment of insurance payments. Any charges in excess of the benefits allowed under the responsible party's insurance plan, I/we understand that I/We are responsible to pay the difference. A finance charge of 1.5% monthly (18% APR) will be added to my outstanding account balance after 30 days.

Authorization to Release Information
Issaquah Dental Arts is hereby authorized to release any medical or incidental information that may be necessary for medical care, or in processing insurance.

Legal Responsible Party
If the patient is a minor and/or under custodial care, the below responsible party represents that they are legally authorized to obtain medical services for the patient.

_____ _____ _____ _____
Responsible Party's Signature *Responsible Party's Printed Name* *Date* *Relationship to Patient*

Issaquah Dental Arts | Merkel & Hansen, pllc

Our approach to dental care is understanding your total well-being. Any and all of the below information will be kept strictly confidential.

Name_____ Date of Birth_____ Date_____

Dental:

1. Are you in any discomfort at this time? (if yes please explain)_____ Yes No
2. When was your last dental visit?_____
3. Does dental treatment make you anxious? not at all slightly moderately extremely
4. any dental concerns/history of teeth or periodontal (Gum) problems? (if yes please explain) .....Yes No

_____

Medical:

1. Has there been any change in your general health within the past year?..... Yes No
2. Date of your last physical examination _____
3. Are you currently under the care of a physician?..... Yes No
   If so, what is the condition being treated?_____
4. any serious illness, been hospitalized or had an operation within the past five years?..... Yes No
   If yes, please explain_____
5. Do you have or have you had any of the following diseases or problems?
   a) Cardiovascular disease (heart trouble, heart attack, heart murmur, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, etc.).....Yes No
   b) Rheumatic fever/rheumatic heart disease.. Yes No
   c) Artificial or replacement valves?..... Yes No
   d) Pacemaker?..... Yes No
   e) Allergy/Sinus/Asthma..... Yes No
   f) Hives or a skin rash?..... Yes No
   g) Fainting spells or seizures?..... Yes No
   h) Hepatitis, jaundice, or liver disease?..... Yes No
   i) Diabetes..... Yes No
   j) Arthritis/inflammatory rheumatism? Yes No
   k) Artificial joints, prosthetic?..... Yes No
   l) Ulcers/stomach disorders? ..... Yes No
   m) Kidney trouble?..... Yes No
   n) Tuberculosis?..... Yes No
   o) Persistent cough/cough up blood?....Yes No
   p) AIDS, HIV or ARC.....Yes No
6. Have you had abnormal bleeding associated with previous extractions, surgery or trauma?.....Yes No
   a) Do you bruise easily?..... Yes No
   b) Have you ever required a blood transfusion?..... Yes No
7. Do you have any blood disorder such as anemia?..... Yes No
8. Have you had surgery or x-ray treatment for a tumor, growth, or other condition?.....Yes No
9. Are you taking any of the following: (Please include name, dose and frequency)
   a) Antibiotics of any kind_____ Yes No
   b) Anticoagulants (blood thinners)_____ Yes No
   c) Medicine for high blood pressure_____ Yes No
   d) Cortisone (steroids)_____ Yes No
   e) Tranquilizers_____ Yes No
   f) Antihistamines_____ Yes No
   g) Aspirin_____ Yes No
   h) Insulin, tobutamide (Orinase) or similar drug for diabetes_____ Yes No
   i) Digitalis or drugs for heart trouble_____ Yes No
   j) Nitroglycerin_____ Yes No
   k) Any other medications not listed above, please list name, dosage, and frequency

   _____
10. Are you allergic or have you reacted adversely to:
    a) Local anesthetics..... Yes No
    b) Penicillin or other antibiotics..... Yes No
    c) Sulfa drugs..... Yes No
    d) Barbiturates, sedatives, or sleeping pills... Yes No
    e) Aspirin.....Yes No
    f) Iodine.....Yes No
    g) Codeine or other narcotics.....Yes No
    h) Other_____
11. Do you use tobacco products?.....Yes No, If so, how much per day and for how long_____
12. Do you use alcohol?.....Yes No, If so, how much per day/week/or month_____
13. Do you have any disease, condition, or problem that was not listed above?..... Yes No
    If so, please explain_____
14. Do you wear contact lenses?..... Yes No
15. WOMEN: a) Are you pregnant or nursing?..... Yes No b) birth control /hormone therapy?....Yes No

To the best of my knowledge, all the preceding answers are true and correct. If I ever have any change in my health or change in my medications, I will inform the dentist at the next appointment.

Signature of Patient:_____ Date:_____

Issaquah Dental Arts
Merkel & Hansen, pllc
Financial Policy

We understand and appreciate your concerns regarding fees associated with your treatment, and feel that you should have a clear understanding of your financial commitment for services provided. We will be happy to discuss fees anytime prior to treatment so that you may fully understand our mutual obligations and responsibilities.

Patients with Insurance

As a service to you, we will complete and file your insurance claim forms for completed treatment. Your insurance is a contract between you, your employer, and the insurance company; we are not a party to that contract. We must emphasize that as dental care providers, our relationship is with you, not your insurance company, therefore all charges are your responsibility from the date services are rendered.

Please remember that insurance plans are usually not designed to pay for everything. We urge you to read your policy. We will do our utmost to see that you receive maximum benefits within the structure of your insurance plan.

Your portion of payment and co-pay (the costs your insurance will not cover) are expected at time of service. We will make every effort to provide you with an accurate estimate of your payment before services are completed.

Patients with No Insurance

If you have no insurance, payment for services is expected at the time of treatment, To assist you, we offer the following options for payment:

CASH/CHECK PAYMENT
CREDIT CARD PAYMENT (VISA, MATERCARD, DISCOVER)

Missed Appointments

We make every attempt to confirm appointments through email, mail, and telephone. If an appointment is missed without providing our office at least 24 hours notice, we reserve the right to apply a missed appointment charge of a minimum of $75.00.

Acknowledgment of the Financial Policy

_____ _____ _____ _____

Responsible Party's Signature *Responsible Party's Printed Name* *Date* *Relationship to Patient*

ISSAQUAH DENTAL ARTS | MERKEL & HANSEN, PLLC

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 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 reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request. You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in the Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determining using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards or letters.)

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practically do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, healthcare operations and certain other activities for the last six years but not before April 14, 2003. If you request this accounting more than once in a 12 month period we may charge you a reasonable, cost based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in emergency)

Alternative Communication: You have the right to request that we communicate with your about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means of locations, and provide satisfactory explanation how payments will be handles under the alternative means or location you request

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain whey the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail) you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of the Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Office Manager Issaquah Dental Arts
Telephone 425-837-0634
Fax 425-837-0636
Email: office@issaquahdentalarts.com

Address: Issaquah Dental Arts
710 NW Juniper Street, Suite 206
Issaquah, WA 98027

Issaquah Dental Arts
Merkel & Hansen, pllc
Financial Policy

NOTICE OF PRIVACY PRACTICES –ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Office Manager.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature | Date

_____ _____

Printed name if signed on behalf of the patient | Relationship
(Parent, legal guardian, personal representative)

This form will be retained in your dental records.

Last Update:____/____/____