smiles on madison
family & cosmetic dentistry

Dr. Joe N. Kim

2209 East Madison Street • Seattle, Washington 98112 • 206.788.4488 • www.SmilesMadison.com

PATIENT INFORMATION (Please Print)

Name _____ Preferred Name _____
Last First M.I.

Home # _____ Work # _____ Cell # _____

Birth Date _____ Soc. Sec. # _____

Address _____
Street City State Zip

Email _____ Referred By _____

RESPONSIBLE PARTY (If other than patient)

Name _____
Last First M.I.

Relationship to Patient _____ Email _____

Home # _____ Work # _____ Cell # _____

Address _____
Street City State Zip

Birth Date _____ Soc. Sec. # _____

EMERGENCY CONTACT

Name _____ Phone _____

Relationship to Patient _____

INSURANCE INFORMATION

	(Primary)	(Secondary)
Insurance Company	1. _____	2. _____
Name of Insured	1. _____	2. _____
Birth Date of Insured	1. _____	2. _____
Relationship to Patient	1. _____	2. _____
Social Security # of Insured	1. _____	2. _____
Employer	1. _____	2. _____
Policy or Group No.	1. _____	2. _____

DENTAL HISTORY

Previous Dentist _____ City _____

When was your last dental exam? _____

What is your immediate dental concern? _____

Please check yes or no if you have, or ever had the following:

	Yes	No		Yes	No
Unhappy with appearance of your teeth	☐	☐	Burning sensation in your mouth	☐	☐
Unfavorable dental experiences/dental fears	☐	☐	Difficulty swallowing	☐	☐
Preference for no dental anesthetic	☐	☐	An unpleasant taste or odor in your mouth	☐	☐
Problems with effectiveness or			Jaw problems (temporomandibular joint)	☐	☐
had reactions to dental anesthetic	☐	☐	Difficulty opening your mouth widely	☐	☐
Orthodontic treatment (braces) when _____	☐	☐	Stiff neck muscles	☐	☐
Periodontal (gum) treatment when _____	☐	☐	Awaken with an awareness of your teeth or jaws	☐	☐
Bleeding gums	☐	☐	Tension headaches	☐	☐
Avoid brushing any part of your mouth	☐	☐	Clench or grind your teeth	☐	☐
Part of your mouth is sensitive to temperature	☐	☐	Jaw clicking or popping	☐	☐
Sore teeth	☐	☐	Lost any teeth	☐	☐

Are you allergic to any of the following? Aspirin Penicillin Erythromycin Codeine Latex Local Anesthetic Fluoride Metals (gold, stainless steel) Other _____

MEDICAL HISTORY

Physician Name _____ Phone _____

Please check yes or no if you have, or ever had the following:

	Yes	No		Yes	No
Hospitalization for illness or injury	☐	☐	Head or neck injuries	☐	☐
Heart problems	☐	☐	Epilepsy, convulsions (seizures)	☐	☐
Heart murmur	☐	☐	Viral infections and cold sores	☐	☐
Rheumatic fever	☐	☐	Any lumps or swelling in the mouth	☐	☐
Scarlet fever	☐	☐	Hives, skin rash, hay fever	☐	☐
High blood pressure	☐	☐	Venereal disease	☐	☐
Low blood pressure	☐	☐	Hepatitis (type) _____	☐	☐
A stroke	☐	☐	AIDS / HIV Positive	☐	☐
Artificial prosthesis (i.e. heart valve or joints)	☐	☐	Cancer, tumor, abnormal growth	☐	☐
Anemia or other blood disorder	☐	☐	Radiation therapy	☐	☐
Prolonged bleeding	☐	☐	Chemotherapy	☐	☐
Emphysema	☐	☐	Emotional problems	☐	☐
Tuberculosis	☐	☐	Psychiatric treatment	☐	☐
Asthma	☐	☐	Antidepressant medication	☐	☐
Sinus problems	☐	☐	Alcohol / drug dependency	☐	☐
Diabetes	☐	☐	Presently treating for any illness _____	☐	☐
Kidney disease	☐	☐	Aware of a change in your general health	☐	☐
Liver disease	☐	☐	Often exhausted or fatigued	☐	☐
Jaundice	☐	☐	Subject to frequent headaches	☐	☐
Thyroid or parathyroid disease	☐	☐	Smoker	☐	☐
Stomach or duodenal ulcer	☐	☐	Generally a nervous person	☐	☐
Arthritis	☐	☐	Often unhappy or depressed	☐	☐
Osteoporosis	☐	☐	Taking birth control pills	☐	☐
Glaucoma	☐	☐	Pregnant	☐	☐
Contact lenses	☐	☐	Prostate disorders	☐	☐

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment.

_____

List any medications taken within the last two years _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____

Signature of Patient (Parent or Guardian) Date

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FINANCIAL POLICY

Payment is due at the time of service. We accept cash, checks, VISA, MasterCard, and American Express. We do not offer payment plans. A charge of $40 will apply to all NSF and returned checks. All accounts balances over 60 days may be subject to a finance charge of 1.0% per month, which is an annual rate of 12%.

*Please read and initial*_____

INSURANCE BENEFITS

We accept assignment of insurance benefits and will file your insurance claim for you. However, we require your ESTIMATED patient portion to be paid at the time of service. In the event that your insurance pays less than the estimated amount, you are responsible for the remaining unpaid balance. While we make good faith efforts to provide accurate treatment plan estimates, it is not always possible to know the exact amount the insurance company will pay. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. All charges are your responsibility from the date services are rendered.

*Please read and initial*_____

CANCELLATION, MISSED OR BROKEN APPOINTMENT POLICY

We require a minimum of 48 business hours notice to reschedule or cancel an appointment. If less than 48 business hours notice is given, a $75 per scheduled hour fee may be assessed to your account.

*Please read and initial*_____

CONSENT TO TREATMENT

I authorize and give consent for the dental treatment of the person stated below and agree to pay all charges for each visit.

All minors (patients younger than 18 years of age) must be accompanied by a parent or legal guardian during the entire length of the minor's appointment. We ask that parents/legal guardians remain in the waiting room during the appointment. Unaccompanied minors will be denied treatment.

We reserve the right to change our policies without notification.

Signing below indicates that you have read the above policies and agree to the terms.

_____ _____

PRINT PATIENT NAME SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN) DATE

_____ _____

IF SIGNED BY PARENT/LEGAL GUARDIAN, PRINT NAME AND RELATIONSHIP TO PATIENT DATE

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 Smiles on Madison. 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 performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Smiles on Madison 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 Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

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 the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number: **Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	**☐ YES**	**☐ NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	**☐**	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

STATEMENT OF PRIVACY PRACTICES

SMILES ON MADISON

Our office is dedicated to protecting the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and 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 or disclosed to anyone – even family members – without your consent or written authorization. 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, integrity, and access to 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.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

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 HEALTHCARE 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 or fund-raising 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 unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

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 Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a 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.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.