David Ford, DDS
EXPECT THE EXCEPTIONAL

David B. Ford, DDS
601 S. Carr Road
Suite 400
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PATIENT INFORMATION

Name:_____ Preferred Name:_____
Last First M

Date of Birth:_____ ☐ Male ☐ Female ☐ Married ☐ Single

Address:_____
Street City Zip Code

Phone: Hm _____ Wk _____ Cell_____

Place of Employment: _____

Social Security Number: _____-_____-_____

Email Address: _____

Whom may we Thank for referring you? _____

Physician's Name_____ Phone No._____

SPOUSE INFORMATION

NAME_____

SS # _____

BIRTHDAY _____

CELL_____

EMPLOYER _____

How can we best reach you for general questions? ☐ Cell ☐ Text ☐ Work ☐ Home ☐ Email

Time of Day_____ ☐ AM ☐ PM

How can we best reach you for confirming appointments? ☐ Cell ☐ Text ☐ Work ☐ Home ☐ Email

Time of Day_____ ☐ AM ☐ PM

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT?

Name_____ Hm Phone No. _____ Wk Phone No._____

Relationship to Patient_____

INSURANCE INFORMATION

Primary Insurance: (PLEASE PRESENT INSURANCE CARD TO RECEPTIONIST)

Insurance company:_____ Group #:_____

Subscriber's name:_____
Last First M

Subscriber's S.S. #: _____-_____-_____ Subscriber's Date of Birth:_____

Patient's relationship to Subscriber: ☐Self ☐ Spouse ☐ Dependent

Secondary Insurance:

Insurance company:_____ Group #:_____

Subscriber's name:_____
Last First M

Subscriber's S.S. #: _____-_____-_____ Subscriber's Date of Birth:_____

Patient's relationship to Subscriber: ☐ Self ☐ Spouse ☐Dependent

– OVER –

DENTAL HISTORY

YES / NO Do you have a specific dental problem or concern? If yes, please state: _____

YES / NO Have you had an upsetting experience in a dental office or do you feel nervous about having dental treatment? _____

YES / NO Do you have TMJ problems? (Bruxing, grinding teeth / popping, clicking or discomfort around jaw joint)

(Optional) Name of previous dentist where we may obtain prior x-rays, etc.: _____

When was your last dental exam? _____

MEDICAL HISTORY

Medical doctor's name _____ phone no. _____ Date of last physical exam:_____

YES / NO Has your physician ever indicated that you should be **pre-medicated with antibiotics** prior to dental treatment?

If so, for what condition were you premedicated? _____

YES / NO Are you under a doctor's care now? For what condition? _____

YES / NO Have you been hospitalized or had surgery in the last 5 years? If yes, please explain: _____

YES / NO Have you had surgery or x-ray treatment for tumor, growth, or other condition of your mouth or lips? _____

YES / NO Have you had abnormal bleeding associated with previous extractions, surgery, or trauma? _____

YES / NO Do you or have you used tobacco products? If so, which _____

YES / NO ***women:*** Are you pregnant? How many months? _____ If recently given birth, are you breastfeeding? ☐Y / ☐N

YES / NO Are you taking **any prescription or over-the-counter medications? (**PLEASE LIST)_____

Please ***check*** any condition that you have now, or have had in the past:

- ☐ **Cardiovascular disease:** (heart attack, coronary insufficiency, coronary occlusion, high/low blood pressure, arteriosclerosis, stroke, pacemaker)
- ☐ **Heart Problems:** prosthetic valve, endocarditis, congenital heart disease, transplant w/ valvulopathy
- ☐ Rheumatic fever, mitral valve prolapse or heart murmur
- ☐ Arthritis or Inflammatory rheumatism
- ☐ Seizures, fainting spells or epilepsy
- ☐ Cancer---type:_____
- ☐ Blood disorder, anemia or slow clotting
- ☐ Hyper- or hypothyroidism
- ☐ Liver: Jaundice, Hepatitis A/B/C, Cirrhosis
- ☐ Kidney: Renal failure, Shunt, Dialysis
- ☐ Tuberculosis
- ☐ Diabetes
- ☐ Glaucoma
- ☐ Chemotherapy or radiation
- ☐ Blood transfusion---year:_____
- ☐ Cold sores or herpes virus
- ☐ Positive HIV, AIDS, or AIDS related complex
- ☐ Frequent allergies, hives or rash
- ☐ Artificial prosthesis/implants (joints, hip screws, etc.?) year:_____
- ☐ Is there any condition, not listed above, that we should know about? _____

Please ***check*** if you are taking ***any*** of the following medications:

- ☐ Antibiotics or sulfa drugs
- ☐ Medicine for high blood pressure
- ☐ Tranquilizers
- ☐ Aspirin
- ☐ Digitalis or drugs for heart trouble
- ☐ Antidepressants :_____
- ☐ Anticoagulants (blood thinners)
- ☐ Bisphosphonates (Boniva, Actonel, Fosamax, Skelid, or Didronel)
- ☐ Antihistamines
- ☐ Insulin (for diabetes)
- ☐ Nitroglycerin

OTHER: _____

Please ***check*** if you are ***allergic*** or have reacted adversely to any of the following medications:

- ☐ Local anesthetics
- ☐ Sulfa drugs
- ☐ Aspirin, tylenol, ibuprofen
- ☐ Barbiturates, benzodiazapines, sleeping pills
- ☐ Penicillin or other antibiotics
- ☐ Latex
- ☐ Codeine or other narcotics (e.g. Tylenol 3, Vicodin, Percocet)

OTHER: _____

The information provided on this medical history form is correct, to the best of my knowledge:

_____ _____

(SIGNATURE OF PATIENT OR RESPONSIBLE PARTY) (DATE)

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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 principal 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.

Collecting Protected Health 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 Health Information

We may disclose information as allowed or 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. You have a right to request and we will honor you written authorization to withhold disclosure to your dental insurance carrier for all services for which you have made full out-of-pocket payment.

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 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.

Please ask if you have any questions about your privacy rights or the protection of your health information.

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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 David Ford, DDS. 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.

David Ford, DDS reserves the right to change the privacy practices that are 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 to me.

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 or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained		
PROVIDED PRIOR TO TREATMENT?	☐ **YES** ☐ **NO**	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):

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Appointment Cancellation Policy

When you schedule an appointment in our office we reserve that time specifically for you. If you need to cancel or reschedule your appointment we require 48 hours advance notice so that we can schedule another patient waiting for treatment. If you miss your appointment or do not give 48 hour notice, there may be a $75/hr charge applied to your account. _____
please intial

Office Financial Policy

Insurance
If you have dental insurance, we will make a good faith estimate of the amount your insurance carrier may pay based on the information provided to us. As the insured, it is your responsibility to determine the coverage by your insurance for any dental services provided in our office. As a courtesy, we will file all dental claims on your behalf as well as provide any information required by your insurance carrier to ensure it is processed in a timely manner. If your insurer denies coverage, or if we otherwise do not receive payment within 60 days from filling your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurer and/or your employer and your insurer. All questions regarding your insurance benefits must be addressed to your insurance carrier. _____
please initial

Payment
The amount estimated to be your portion of treatment, is due at the time dental treatment is provided. We accept payment in the forms of Cash/Check, Visa, Mastercard, Discover, Debit cards (that bear Visa or MasterCard logos), and Care Credit.

Patient Responsibility, Assignment and Release
I acknowledge my responsibility for the total payment of all services performed in this office in accordance with their regular fees and terms.

I understand my responsibility is not modified by whether any third party (insurance) pays for all, part, or none of the charges. I understand that any estimated portion, not covered by insurance is due at the time of service for all services rendered.

I understand that my account becomes *delinquent if not paid within sixty (60) days after billing* and that at that time a finance charge of 1.0% of the unpaid balance will be charged every month until the balance is paid in full (RCW 19.52.020).

I authorize payment to be made directly to the dentist by my insurance company and I accept financial responsibility for all services not covered by my insurance. I authorize release of any medical/dental care information requested by my insurance carrier, and authorize my insurance company to pay insurance benefits directly to the dentist for all dental services rendered.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an exceptional experience!

I have read and understand the Office Financial and Appointment Cancellation Policies.

Name of Patient_____ Patient Signature_____

Guardian Signature_____ Date_____