



15946 Redmond Way Suite 106 • Redmond, WA 90852 • 425-898-2168

Patient's Information

Today's Date: _____
Full Legal Name: _____
Preferred Name: _____
Preferred Pronoun: He She They
Date of Birth: _____ male female
Home Address: _____

City/State: _____ Zip: _____
Social Security #: _____
Cellphone #: _____
Home #: _____
Work #: _____
Email: _____

Which is the best way to reach you?
 Phone call Email Text Home # Work #

How did you hear about us?

Google Bing YELP Insurance Search Other
 Friend : _____

What Keywords did you use to find us?
(e.g. Redmond Dentist, emergency dentist, etc)

Previous Dentist: _____

Emergency Contact

Name: _____
Phone #: _____
Relationship: _____

Dental Insurance Information

Policy Holder: _____
Employer: _____
Date of Birth: _____
Insurance Provider: _____
ID #: _____
Group #: _____

Secondary Insurance Information

Policy Holder: _____
Employer: _____
Date of Birth: _____
Insurance Provider: _____
ID #: _____
Group #: _____

I understand that I am responsible for informing Redmond Way Dentistry of changes to my insurance information. I hereby authorize payment directly to Redmond Way Dentistry for the group insurance benefits otherwise payable to me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Patient Name (Print) : _____

Patient Signature: _____ **Date:** _____

CONTINUE TO NEXT PAGE →

REDMOND WAY DENTISTRY MEDICAL HISTORY FORM

1. Are you under medical treatment now? _____ YES NO
If so, what? _____
2. Have you been hospitalized for any surgical operations or serious illness? _____ YES NO
If so, what? _____
3. Are you taking any medicines including non-prescription medicine? _____ YES NO
If so, what? _____
4. Are you required to pre-medicate before dental treatment? _____ YES NO
If so, what? _____

Treating Physician's Name : _____ Phone Number _____
Date of Last physical Exam : _____

Allergies to Medicines

Are you allergic to or have you had any reactions to the following?

NO KNOWN ALLERGIES

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Ibuprofen | <input type="checkbox"/> Penicillin / Amoxicillin |
| <input type="checkbox"/> Barbiturates | <input type="checkbox"/> Latex | <input type="checkbox"/> Sedatives |
| <input type="checkbox"/> Codeine | <input type="checkbox"/> Local Anesthetics (i.e. Novocain) | <input type="checkbox"/> Sulfa Drugs |
| <input type="checkbox"/> Other _____ | | |

Medical Conditions

Please check the boxes if you have or have had any of the following

- | | | |
|--|---|--|
| <input type="checkbox"/> AIDS / HIV Infection | <input type="checkbox"/> Hay Fever / Seasonal Allergies | <input type="checkbox"/> Night Sweats accompanied by weight loss or cough |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Attack / Heart Disease | <input type="checkbox"/> Recent Weight Loss |
| <input type="checkbox"/> Angina / Chest Pains | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> Anxiety with dental care | <input type="checkbox"/> Hepatitis / Jaundice | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Troubles / Ulcers |
| <input type="checkbox"/> Cancer / Radiation Therapy | <input type="checkbox"/> Intestinal Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cardiac Pacemaker | <input type="checkbox"/> Joint Replacement / Implants / Screws / Pins | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney / Liver Disease | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Tumors or Growths |
| <input type="checkbox"/> Epilepsy / Convulsions | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Weight Reduction Surgery |
| <input type="checkbox"/> Fainting / Seizures | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Wounds that heal slowly or present with other complications |
| <input type="checkbox"/> Have you been treated for Alcohol or Chemical dependency? | | |

WOMEN : Taking Birth Control Pills Nursing Pregnant or think you may be pregnant (due date : _____)

What is your main reason for visiting Redmond Way Dentistry?

- General checkup Emergency visit Consultation Other : _____

Patient Name (Print) : _____

Patient Signature: _____ Date: _____

CONTINUE TO NEXT PAGE →

REDMOND WAY DENTISTRY FINANCIAL POLICY

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Thank you for choosing Redmond Way Dentistry as your dental health care provider. It is our commitment to provide quality care to our patients and avoid misunderstandings. At this time, we would like to inform you of our office policy regarding payment for services rendered.

All fees, including co-payments and deductibles, are due at the time of service. For your convenience we accept the following forms of payment: cash and credit cards. We also offer Care Credit Financing that allows you to pay with interest free monthly payments. For more information please ask our front office staff.

Our office will bill your insurance company as a courtesy to you. We will provide you with an insurance estimate prior to any treatment being performed. This is just an estimate and the amount the insurance company pays may be different than what we have estimated. **If for any reason your insurance does not pay the estimated amount, you will become responsible for the balance.**

Sometimes treatment may differ from the proposed treatment plan that you were given during the examination appointment. You will be informed of any of these unforeseen changes and given a new estimate.

REDMOND WAY DENTISTRY MISSED/CANCELLED APPOINTMENT POLICY

If you cannot come to your scheduled dental appointment, **please call the office at least 48 hours prior** to the appointment (2 business days). This allows us to fill the time with another patient. Please be on time for your appointment. If you are more than 15 minutes late we may have to reschedule your appointment.

ALL APPOINTMENTS CANCELLED WITHOUT 48 HOURS (2 BUSINESS DAYS) NOTICE CARRY A MISSED APPOINTMENT FEE OF \$100 PER SCHEDULED HOUR.

I have read and understand both the financial policy and missed/cancelled appointment policy above for Redmond Way Dentistry.

Patient Name (Print) : _____

Patient Signature: _____ Date: _____

CONTINUE TO NEXT PAGE →

REDMOND WAY DENTISTRY
CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we may make of your protected health information and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a written copy of our Notice of Privacy Practices at any time by contacting:

Contact Officer: Becky Ferrell
Telephone: 425-898-2168

Right to Revoke: You have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took prior to your revocation.

I, as the Patient or the Patient's Representative, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I hereby specifically authorize disclosure of my protected health care information to the persons indicated below:

ANY MEMBER OF MY IMMEDIATE FAMILY SPOUSE / PARTNER ONLY OTHER _____

Patient Name (Print) : _____

Patient Signature: _____ **Date:** _____

(If this Consent is signed by a Personal Representative on behalf of the patient, please complete the following)
Representative's Name : (print) _____ Relationship to Patient : _____
Representative's Signature : _____ Date: _____

Please complete the following ONLY if you would like a copy of this form. You are entitled to a copy.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

Patient's Name: (print) _____ **Date:** _____

Patient's Signature: _____

I, (Print signature name, if signing as Representative) _____, have received a copy of this office's Notice of Privacy Practices. Signature of Representative _____

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign Communication barriers prohibited obtaining the acknowledgement
 An emergency situation prevented us from obtaining acknowledgment Other (Please specify) _____