Devin Dickinson
DDS

PATIENT INFORMATION

Patient Name_____Preferred Name _____

Date of birth_____ Sex_____ SSN#_____Employer_____

Home address_____ City_____ State_____ Zip_____

Home Phone_____ Cell_____ Email_____

I would prefer appointment reminders by: □ text □ email □ both

How did you hear about us?_____

BILLING & INSURANCE INFORMATION

Billing address (if different from home)_____ City_____ State_____ Zip_____

Primary dental insurance_____ Group #_____ ID #_____

Subscriber's name_____ Date of birth_____ SSN#_____

Secondary dental insurance_____ Group #_____ ID #_____

Subscriber's name_____ Date of birth_____ SSN#_____

Company of Employment_____ Phone Number_____

DENTAL HISTORY

Reason for today's visit_____ Date of last dental care_____

Former Dentist _____ Date of last dental x-rays_____

Address_____ Phone_____

Are you apprehensive about dental treatment? □ Yes □ No

Have you had problems with previous dental treatment? □ Yes □ No

Are you interested in? □ Whitening your teeth □ Cosmetic treatment □ Braces or Invisalign

Are you satisfied with the appearance of your teeth? □ Yes □ No

Check (x) if you have had any of the following

□ Bad breath
□ Bleeding gums
□ Clicking or popping jaw
□ Dentures
□ Difficulty chewing food
□ Dry mouth
□ Food collection between teeth
□ Gag easily
□ Headaches or jaw pain in morning
□ Grinding/clenching teeth
□ Loose teeth or broken fillings
□ Orthodontic treatment
□ Pain in/near ear
□ Pain due to brushing
□ Periodontal (gum) treatment
□ Sores or growths in your mouth
□ Sensitivity to hot
□ Sensitivity to sweets
□ Sensitivity when biting
□ Sensitivity to cold
□ Tender or swollen gums
□ Trauma to jaw

MEDICAL HISTORY

Physician's Name_____ Date of last visit_____ Phone_____

Emergency contact_____ Emergency phone_____

Check (x) if you have or have had any of the following:

□ Acid Reflux	□ ADHD/ADD	□ Allergies	□ Anemia
□ Angina	□ Anxiety	□ Artificial Heart Valves	□ Arthritis
□ Artificial Joints	□ Asthma	□ Back problems	□ Blood Disease
□ Cancer	□ Chemical Dependency	□ Chemotherapy	□ Circulatory Problems
□ COPD	□ Cortisone Treatments	□ Cough, persistent	□ Crohn's Disease
□ Depression	□ Developmental Disorder	□ Diabetes	□ Epilepsy
□ Fainting	□ Fatigue	□ Fibromyalgia	□ Glaucoma
□ Headaches	□ Heart attack	□ Heart murmur	□ Heart Problems
□ Hemophilia	□ Hepatitis	□ High blood pressure	□ High Cholesterol
□ HIV / AIDS	□ Hx of Bisphosphonates	□ Insomnia	□ Kidney Disease
□ Liver Disease	□ Mental Disorder	□ Mitral valve prolapse	□ Multiple Sclerosis
□ Neurological Disease	□ Osteopenia	□ Osteoporosis	□ Other
□ Pacemaker	□ Radiation Treatment	□ Recreational Drugs	□ Respiratory Problems
□ Shortness of Breath	□ Skin Rash	□ Sleep apnea	□ Snoring
□ STD	□ Stomach Problems	□ Stroke	□ Swelling of feet/ankles
□ Thyroid Problems	□ Tobacco Habit	□ Tuberculosis	□ Tumors

(Women) Are you pregnant? □ Yes □ No Nursing? □ Yes □ No Taking birth control pills? □ Yes □ No

If any conditions selected need further clarification including allergies, please describe below:

_____

_____

If you have a disease, condition, or problem not previously listed, please describe below:

_____

_____

Has your doctor told you to take premedication prior to dental treatment? □ Yes □ No If yes, please explain?

_____

MEDICATIONS

Please list any medications you are currently taking:

_____

_____

Devin Dickinson
DDS

Official Financial Guidelines

We accept Cash, Check, Mastercard, Visa, American Express, and Discover. We also offer Care Credit as a financing option for those who qualify. Patient portion is due at the time of service.

As a courtesy to our patients we will research, to the best of our ability, the benefits you have available and file your insurance claims for you. Your insurance is a contract between you and your insurance company and does not guarantee payment. As a condition of treatment by our office, financial arrangements must be made in advance. The practice depends on reimbursement from patients for the costs incurred in our care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time the services are performed unless other arrangements are made.

A service charge of .75% per month (9% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless other signed financial arrangements have been made.

I understand that any estimated fees for dental care can only be extended for a period of six months from the date of the treatment diagnosis.

In consideration for the professional services rendered to me by this practice, I agree to pay the charges for the services at the time of treatment or within 5 days of billing. I further agree that the charges for services shall be as billed unless objected to, by me, in writing, within the time payment is due. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted herunder.

A returned check fee of $35.00 will be assessed on any account having non-sufficient funds. A $50.00 fee may be assessed for broken/failed appointments without two business days notice. Arriving for an appointment 15 minutes late or more may result in a failed appointment.

My electronic signature confirms I have read, understand, and agree to the above guidelines. I have been given a copy of these guidelines.

Devin Dickinson, D.D.S.
302 E. Division
Arlington, WA 98223
360-435-3661

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Devin Dickinson, D.D.S. 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. Devin Dickinson, D.D.S., 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 have 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

This Portion is for Office Use

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).

Dr. Devin Dickinson Privacy Policies

The information provided below illustrates the manner your protected health information could be accessed and released and what you need to know about this process. This important document should be reviewed thoroughly. Managing the privacy of your protected health information is extremely important to Dr. Devin Dickinson.

Legal Responsibilities of Dr. Devin Dickinson: As mandated by Federal and State legal requirements your protected health information must be protected. As part of these regulations we are required to ensure you are aware of privacy policies, legal duties and your rights to your protected health information. This notice of privacy policies, outlined below, will be in effect for the duration and must be followed by our practice.

We reserve the right to modify our privacy policies and the terms of this notice at any time, and will make such modifications within the guidelines of the law. We reserve the right to make the modifications effective for all protected health information that we maintain, including protected health information we created or received before the changes were made. Changing this notice will precede all significant modifications.

PROTECTED HEALTH INFORMATION USE AND DISCLOSURE: Information regarding your health may be used and disclosed for the purpose of treatment, payment and other healthcare operations.

Treatment: Use and disclosure of your protected health information may be provided to a physician or other healthcare provider providing treatment to you.

Payment: Your protected health information may be used and disclosed to obtain payment for services we provided to you.

Healthcare Processes: We may use and disclose your protected healthcare information in relations with our healthcare process. These processes include an assessment, improvement activities, reviewing the competence or qualifications of healthcare professionals, provider performances and evaluating practitioner, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: At any time you may provide in writing your authorization for use and disclosure of your protected health information for any purpose. You may choose to revoke your written permission at any time. The revocation must be in writing. If you revoke your written authorization it will not affect any use or disclosure prior to the revocation.

Your protected health care information may be used and disclosed to you, as described in the patient rights section of this notice. In addition, your protected health information may be used and disclosed to a family member, friend, or other person to the extent necessary to assist you with your healthcare, but only with your authorization.

Person Involved in Care: In order to accommodate the notification of your location, your general condition, or death, your protected health information may be used or disclosed to a family member, your personal representative or another person responsible for your care. If you are present and wish to object to such disclosures of your protected health information you may do so. To the extent you are incapacitated or emergency circumstances exist, we will disclose protected health information using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your healthcare. We will use our professional judgment and our experience with common practices 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 protected health information.

Marketing Health-Related Services: The use of your protected health information for the purpose of marketing communications is prohibited without you're written authorization.

Required by Law: Your protected health information may be used or disclosed if required by law.

Abuse or Neglect: As required by law, if we have reason to believe that you are the victim of possible abuse, neglect or domestic violence or other possible crimes, your protected health information may be disclosed to the appropriate authorities. If we have reason to believe the use or disclosure of your protected health information will prevent a serious threat to your health or safety or the health or safety of others we may have to provide the necessary protected health information.

National Security: Under some circumstances the military may require disclosure of health care information for armed forces personnel. For the purpose of national securities activities, counter intelligence and lawful intelligence, authorized federal authorities may require disclosure of protected health information. Protected health care information disclosure may be made to correctional facilities or law enforcement authorities with the lawful authority requiring custody of such information.

Appointment Reminders: Your protected health care information may be used to assist you with appointment reminders in the form of voicemail messages, postcards, or letters.

PATIENT RIGHTS

Access: At all times you have the right to review your protected health information, with limited exceptions. At your request, we will provide your information in a file or email format. If we are able to do so we will accommodate your request.

Your request to obtain access to your information must be in writing. You may obtain a *Protected health information Access Form* by using the contact information at the end of this notice.

Disclosure Accounting: Your rights include the choice to receive a review of every time we or our business associates disclosed your protected health information for reasons other than treatment, payment, healthcare information and certain other activities for the last six years but not before April 14, 2003. Additional reasonable cost based fees may be extended if your requests for such information are more than one time per year.

Restrictions: You may request we apply additional restrictions to any disclosure of your health care information. We are not required to respond to the application of these additional restrictions. If we agree to follow your request regarding additional restrictions we will follow the agreed restrictions unless an emergency situation dictates otherwise.

Alternative Communication: Your rights include the instruction to request how you are communicated to regarding your protected health information. Your request must be in writing and can spell out other ways or others locations regarding your protected health information communication. You must identify agreed upon explanations of payment arrangements under alternative communications.

Amendment: You can initiate a written request to amend your protected health information. Included in the amendment must be an explanation why information should be amended. Certain conditions may exist where we may reject you request.

Electronic Notice: If you receive a notice electronically, you are entitled to receive the notice in writing as well.

QUESTIONS AND COMPLAINTS

If at any time you are unsure or concerned that your protected health information has not been protected or if you believe an error was made in the decision we made about accessing your protected health information; or in the response to a request you made to amend the use or disclosure of your protected health information; or to have us communicate to you by an alternative means or at an alternative locations, you have the right to bring this issue forward. You may make a 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 Service at your request.

Privacy of your protected health information remains extremely important; we are committed to ensure your privacy. If you file a concern with the U.S. Department of Health and Human Resources we will not retaliate in anyway. We are available to assist you with any questions, concerns or complaints.