(360) 435-3661

STILLY VALLEY DENTAL EST. 2014

302 E. Division St, Arlington, WA 98223

Patient Information

Basic Information:

Name:		**Pref Name:**	
Date of Birth:		**Gender:**	
Mobile Phone:		**Marital Status:**	
Home Phone:		**Mailing Address:**	
Email:		**City:**	
SSN #:		**State & ZIP:**	
Employer:		**Referral Source:**	

Emergency/PoA Contact: **Work Information:**

Full Name:		**Street Address:**	
Phone Number:		**City:**	
Relation:		**State & ZIP:**	

Insurance Information – Please fill out according to ***SUBSCRIBERS*** information**:**

Relationship to Insurance Holder:		**Employer:**	
Name:		**Insurance Company:**	
Date of Birth:		**ID Number:**	
SSN#:		**Group Number:**	
Mailing Address:		**Phone # on Card:**	
City:		**Address on Card:**	
State & ZIP:		**City:**	
Phone Number:		**State & ZIP:**	

Secondary Insurance Information *(if applicable)* **–** Please fill out according to **SUBSCRIBERS** information**:**

Relationship to Insurance Holder:		**Employer:**	
Name:		**Insurance Company:**	
Date of Birth:		**ID Number:**	
SSN#:		**Group Number:**	
Mailing Address:		**Phone # on Card:**	
City:		**Address on Card:**	
State & ZIP:		**City:**	
Phone Number:		**State & ZIP:**	

_____ _____

Signature **Date**

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Health History

Please list ALL:

Medical Conditions:	
Allergies:	
Medications:	

General Health Information:

Physician's Name & Phone Number:	
Date of Last Exam:	
Are you being treated for any injury/illness? Explain:	
Have you ever been hospitalized for an injury/illness?	
Have you been told that you require a premedication?	
Do you use Tobacco, how much/often?	
Do you use Marijuana, how much/often?	
Are you taking birth control medication?	
Are you pregnant or planning to become pregnant?	
Are you currently breastfeeding?	

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

	Anemia		Blood Disease		Depression		Heart Attack		Liver Disease		Rheumatic Fever
	Angina		Cancer		Diabetes		Heart Murmur		Narcolepsy		Kidney Disease
	Anxiety		Chemotherapy		Epilepsy		Heart Problems		Insomnia		Skin Rash
	Arthritis, Rheumatism		Chemical Dependency		Shortness of Breath		High Blood Pressure		Respiratory Disease		Mitral valve Prolapse
	Artificial Heart Valves		Circulatory problems		Fatigue		Hepatitis		Neurological Disease		Sleep Apnea
	Artificial Joints		Cough		GERD		HIV / AIDS		Pacemaker		Snoring
	Asthma		Fainting		Glaucoma		Hemophilia		Headaches		Stroke
	Back Problems		Coughing Blood		Cortisone Treatments		Radiation Treatment		Recreational Drugs		Swollen Feet/Ankles
	STD		Thyroid Problems		Tuberculosis		Ulcer				

The above information is accurate and complete to the best of my knowledge. I will not hold my dentist or any member of the staff responsible for any errors or omissions that I may have made in completion of this form.

_____ _____

Signature **Date**

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Notice of Privacy Practices

Effective Date: February 4, 2026

Our Commitment to Your Privacy
Our dental practice is committed to protecting the privacy and confidentiality of your protected health information (PHI). We are required by law to maintain the privacy of your PHI, to provide you with this Notice of Privacy Practices, and to follow the terms of this Notice currently in effect.

This Notice explains how we may use and disclose your PHI, your rights regarding your PHI, our legal duties, and whom to contact for additional information or to file a complaint.

What Is Protected Health Information (PHI)
Protected Health Information (PHI) is individually identifiable health information that relates to your past, present, or future physical or mental health or condition, the provision of health care to you, or payment for that care. PHI may be created, received, maintained, or transmitted in any form, including electronic, paper, or oral communications.

Examples of PHI include, but are not limited to:

- Your name, address, phone number, email address, and date of birth
- Dental and medical histories
- Diagnostic images, X-rays, charts, and clinical notes
- Treatment plans and progress notes
- Insurance and billing information
- Appointment and scheduling records

How We May Use and Disclose Your PHI Without Your Authorization
Federal privacy laws allow us to use and disclose your PHI without your written authorization for certain purposes, including treatment, payment, and health care operations (“TPO”).

1. Treatment: We may use and disclose your PHI to provide, coordinate, or manage your dental care. This includes sharing information with other health care providers, specialists, laboratories, pharmacies, or other entities involved in your treatment.

2. Payment: We may use and disclose your PHI to obtain payment for services provided to you. This may include billing insurance companies, processing claims, determining eligibility or coverage, and collecting copayments or balances.

3. Health Care Operations: We may use and disclose your PHI for activities necessary to operate our practice. These activities may include quality assessment and improvement, staff training, accreditation, licensing, compliance reviews, audits, business planning, and administrative functions.

Other Permitted or Required Uses and Disclosures
We may also use or disclose your PHI without your authorization in the following circumstances, as permitted or required by law:

- To comply with federal, state, or local laws
- For public health activities (e.g., disease prevention, reporting adverse events)
- For health oversight activities (e.g., audits, investigations, inspections)
- In response to court orders, subpoenas, or lawful processes
- For law enforcement purposes, as required by law
- To avert a serious threat to health or safety
- For workers’ compensation or similar programs

Special Protections for Certain Records (Including Substance Use Disorder Records)
Some health information may be subject to additional protections under federal or state law, including records related to substance use disorder (SUD) treatment governed by 42 CFR Part 2.

When applicable:

- Such records may not be used or disclosed without your written consent, except as specifically permitted or required by law
- Redisclosure of this information may be prohibited
- These records generally may not be used in civil, criminal, administrative, or legislative proceedings without specific authorization or a court order

If your information is subject to these additional protections, we will comply with all applicable requirements.

Redisclosure of Information

Information disclosed pursuant to this Notice may be subject to redisclosure by the recipient and may no longer be protected by HIPAA. However, certain information, including substance use disorder records, may remain protected from redisclosure under other applicable laws.

Uses and Disclosures Requiring Your Written Authorization

We will obtain your written authorization before using or disclosing your PHI for purposes not described in this Notice, including:

- Marketing activities not otherwise permitted by law
- Sale of PHI
- Certain disclosures of psychotherapy notes, if applicable

You may revoke an authorization at any time in writing, except to the extent that action has already been taken in reliance on it.

Your Rights Regarding Your PHI

You have the following rights regarding your PHI:

Right to Access

You have the right to inspect and obtain a copy of your PHI, with limited exceptions. Requests must be submitted in writing. We will respond within the timeframe required by law and may charge a reasonable, cost-based fee.

Right to Request Amendment

If you believe your PHI is incorrect or incomplete, you may request an amendment. We may deny your request under certain circumstances, in which case you may submit a written statement of disagreement.

Right to Request Restrictions

You may request restrictions on how we use or disclose your PHI for treatment, payment, or health care operations. We are not required to agree to all requests, except as required by law.

Right to Confidential Communications

You may request that we communicate with you in a specific manner or at a specific location (for example, at an alternate phone number or address).

Right to an Accounting of Disclosures

You may request a list of certain disclosures of your PHI made by us, as permitted by law.

Right to a Paper Copy

You have the right to receive a paper copy of this Notice upon request, even if you have agreed to receive it electronically.

Our Legal Duties

We are required by law to:

- Maintain the privacy and security of your PHI
- Provide you with this Notice explaining our legal duties and privacy practices
- Notify you following a breach of unsecured PHI, as required by law

Complaints

If you believe your privacy rights have been violated, you may file a complaint with:

- Our practice, using the contact information listed above, or
- The U.S. Department of Health and Human Services, Office for Civil Rights

We will not retaliate against you for filing a complaint.

Changes to This Notice

We reserve the right to change the terms of this Notice at any time. Any changes will apply to all PHI we maintain. Updated Notices will be available upon request and posted in our office and on our website, if applicable.

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Acknowledgement of Receipt of Statement of Privacy Practices

I, _____, acknowledge that I have been provided a copy of the Statement of Privacy Practices. I understand that the Health Insurance Portability and Accountability Act (HIPAA) requires health care providers to provide patients with a Notice of Privacy Practices that explains how their protected health information (PHI) may be used and disclosed, as well as their rights regarding their PHI.

Patient's Right to Refuse to Sign:
I understand that I have the right to refuse to sign this acknowledgement form. Refusing to sign this form will not affect my ability to receive treatment. However, by signing this form, I acknowledge that I have received the Statement of Privacy Practices and understand its contents.

Authorization to Share Information with Other Individuals:

I understand that I have the option to authorize the sharing of my PHI with other individuals, including:

1. **Immediate Family:** This includes my parents, children, and siblings.
2. **Extended Family:** This includes other relatives such as grandparents, aunts, uncles, and cousins.
3. **Spouse Only:** This authorizes the sharing of my PHI with my spouse only.
4. **Other Individuals**: I may designate specific individuals not listed above with whom I authorize the sharing of my PHI.

Please specify the name of the individual(s) and their relationship to you in the spaces provided below.

Individuals with Whom Information May be Shared:

Name of Individual(s): _____

Relationship(s) to Patient: _____

Patient Signature: _____

Date: _____

Name of Individual(s): _____

Relationship(s) to Patient: _____

Patient Signature: _____

Date: _____

By signing below, I acknowledge that I have received the Statement of Privacy Practices and understand my rights regarding the use and disclosure of my PHI. I also authorize the sharing of my PHI with the individual(s) listed above, if applicable.

_____ _____

Patient Signature **Date**

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Office Policies & Financial Guidelines

Regarding Insurance: 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. Please keep in mind that your insurance is a contract between you and your insurance company and does not guarantee payment. We cannot bill your insurance company unless you provide us with your insurance information. It is your responsibility to follow your insurance benefit guidelines, which may include limitations and age restrictions. Please check your benefits. Please be aware that if we are not informed you have multiple insurance providers the dental benefits may not be paid by your insurance company and, by default, you will be responsible for unpaid claims. If your insurance plan pays on a Fee Schedule, you must provide a copy of that schedule. Without it, we are unable to accurately estimate benefits for you. Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Regarding Payment:

-For out-of-pocket costs exceeding $1,000: 50% of your patient portion will be due at the time of scheduling, with the remaining balance due on the date of service.
-The patient portion is due at the time of service.
-A returned check fee of $35.00 will be assessed to any account having an NSF (Non-Sufficient Funds) check payment.
-We accept cash, check, credit, and debit cards.
-We offer CareCredit for those who qualify as our only payment plan option.

Regarding late cancel, broken, or missed appointments:

-We require a minimum of 24 hours' notice to reschedule an appointment.
-Our goal is to provide high-quality care to our patients and respect their schedules as well.
-When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. In fairness to other patients and our staff, if you should need to reschedule, we kindly request that you contact us with advanced notice.
-We understand conflicts arise; however, failing your appointment or canceling without 24-hour notice more than once will result in a $75 charge.
-Confirmation is ***required*** for cleaning visits 2 hours or longer. If the appointment is not confirmed by the time given in the final courtesy call, the visit will be removed from our schedule and you must call back to rebook it.
-Patients who continue to **no-show** and/or **cancel** without notice may be dismissed from the practice and asked to find another dentist.

A $75.00 fee may be applied for broken or missed appointments where a minimum of 24 hours' notice is not given. This fee is due PRIOR to rescheduling. If you arrive ten minutes late for an appointment or more, it may be considered a broken appointment.

I have read, understood, and agree with the above appointment policy.

_____ _____

Signature **Date**

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Records Release Form

Patient Name: _____ Date of Birth: _____

Please select which scenario applies to you:

- I want the records from my *previous* dentist to be released.
- I want the records from Stilly Valley Dental to be released to my future office.

Previous dentist's name/practice name: _____

Address: _____

Phone Number: _____

Email Address: _____

Please select to send a copy of:

- All of my dental records (x-rays, chart notes, periodontal charting)
- Dental x-rays only (bitewings, Panorex, Full Mouth Series within five years)
- Other _____

Release of Records Authorization

By signing below, I consent for my dental treatment records to be transferred by email to *frontoffice@stillyvalleydental.com*.

I confirm and agree to the release of my records.

_____ _____

Signature **Date**