# Welcome to Kent Dental Excellence

## Patient Information

Date: _____ Home Phone Number: (____)_____ Cell Phone Number: (____)_____

Name: _____ Patient SS#/ID: _____

Last Name First Name Middle Name Initial

Age: _____ Date of Birth: _____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Widowed ☐ Single ☐ Separated ☐ Divorced ☐ Minor

Address: _____ Email: _____

City: _____ State: _____ ZIP Code: _____

Patient Employer/School Name: _____ Occupation: _____

Employer/School Address: _____ Phone Number: _____

Whom can we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone Number: _____

## Primary Insurance

Person responsible for this account: _____

Last Name First Name Middle Name Initial

Relationship to Patient: _____ Date of Birth: _____ SS #: _____

Address (if different from patient's): _____ Phone Number: _____

City: _____ Sate: _____ ZIP Code: _____

Responsible party employed by: _____ Occupation: _____

Dental Insurance Company: _____ Insurance Company Phone Number: _____

Subscriber/Member ID#: _____ Group Number: _____

Name of other dependents covered by this dental plan: _____

## Additional Insurance

Does the patient have additional dental coverage? ☐ Yes ☐ No

Subscriber Name: _____ Date of Birth: _____

Last Name First Name Middle Name Initial

Relationship to Patient: _____ SS Number: _____

Address (if different from patient's): _____ Phone Number: _____

City: _____ State: _____ ZIP Code: _____

Subscriber employed by: _____ Occupation: _____

Dental Insurance Company: _____ Insurance Company Phone Number: _____

Subscriber/Member ID#: _____ Group Number: _____

Name of other dependents covered by this dental plan: _____

***Please Complete Both Sides***

## Dental History

Reason for Today's Visit: _____ Date of Last Dental Appointment: _____

Name of Previous Dentist: _____ Date of Last Dental X-rays: _____ _____

Phone Number: _____

Check (☑) if you have any of the following:

| | | |
|---|---|---|
| ☐ Bad breath | ☐ Grinding teeth | ☐ Sensitivity to hot |
| ☐ Sensitivity to cold | ☐ Sensitivity to sweets | ☐ Sensitivity when biting |
| ☐ Bleeding gums | ☐ Loose teeth or broken fillings | ☐ Food collection between teeth |
| ☐ Periodontal treatment | ☐ Sores or growths in your mouth | ☐ Clicking or popping jaw |

How often do you floss? _____ How often do you brush? _____

## Medical History

Physician's Name: _____ Date of Last Visit: _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen"? These include combinations of Ionimin, Adipex, Fastin (brand names of phentermine) Podimin (fenfluramina) and Redux (dexfenfluramine). ☐ Yes ☐ No

Have you had any serious illnesses or operations? ☐ Yes ☐ No If yes, please describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, please give approximate dates: _____

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

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

| | | | |
|---|---|---|---|
| ☐ Anemia | ☐ Cortisone Treatments | ☐ Hepatitis: ☐A ☐B ☐C | ☐ Scarlet Fever |
| ☐ Arthritis, Rheumatism | ☐ Cough, Persistent | ☐ High Blood Pressure | ☐ Shortness of Breath |
| ☐ Artificial Heart Valves | ☐ Cough Up Blood | ☐ HIV / AIDS | ☐ Skin Rash |
| ☐ Artificial Joins | ☐ Diabetes | ☐ Jaw Pain | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Swelling of Feet or Ankles |
| ☐ Back Problems | ☐ Fainting | ☐ Liver Disease | ☐ Thyroid Problems |
| ☐ Blood Disease | ☐ Glaucoma | ☐ Mitral Valve Prolapse | ☐ Tobacco Habit |
| ☐ Cancer | ☐ Headaches | ☐ Pacemaker | ☐ Tonsillitis |
| ☐ Chemical Dependency | ☐ Heart Murmur | ☐ Radiation Treatment | ☐ Tuberculosis |
| ☐ Chemotherapy | ☐ Heart Problems | ☐ Respiratory Disease | ☐ Ulcers |
| ☐ Circulatory Problems | ☐ Hemophilia | ☐ Rheumatic Fever | ☐ Venereal Disease |

Current Medications

_____

_____

Allergies

_____

_____

I certify that I, and/or my dependent(s) have dental insurance and we assign Dr. _____ all insurance benefits that are payable for services provided. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above mentioned dentist may use my health care information and may disclose such information to the dental insurance and its agents to obtain payment for services, determine insurance benefits, and the payable benefits for said services. This authorization is valid until revoked in writing.

SIGNATURE: _____ DATE: _____

PRINTED NAME: _____ RELATIONSHIP TO PATIENT: _____

# WELCOME TO KENT DENTAL EXCELLENCE

It is our goal to provide you and your family with the highest quality of dental care while maintaining a friendly and relaxing environment. In order to keep such high standards, we ask that you observe the following guidelines:

**FINANCIAL POLICY: Payment is due at the time of treatment** (unless arrangements have been made in advance). For your convenience, we offer several payment options. We accept cash, credit and debit cards.

**REGARDING INSURANCE:** We accept assignment of insurance benefits however **we do require *your* co-payment at the time of service. The balance of your account is your responsibility whether your insurance pays or not.** Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We bill insurance as a service to our patients. We can also verify your benefits and provide you with an estimate of coverage for treatment, however, it is your responsibility to know and understand your policy and coverage. We are not responsible for any changes in you insurance coverage one an estimate had been provided to you. If your insurance company has not paid your account in full, the entire balance will be your responsibility.

**CANCELLATION POLICY:** Our office requires **a minimum of 48 hours** notice if an appointment must be cancelled, therefore this time can be allotted to patients with emergency needs. **If less than 48 hours notice is not given, a $50 fee will be assessed.**

**STATEMENT OF PRIVACY PRACTICES:** We at Kent Dental Excellence are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that our 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 dental 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.

**COLLECTING PROTECTED HEALTH INFORMATION:** We will only request personal information needed to provide our standard of quality dental care, implement payment, conduct normal dental practice operation, and comply with the law. This may include your name, address, telephone number(s), social security, employment data, medical history, health record, 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:** 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 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.

**PATIENTS RIGHTS:** You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list if insurances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such request must be in immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient of Kent Dental Excellence. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information. Everyone at Kent Dental Excellence looks forward to taking care of your oral health needs and welcomes you to our practice.

**I have read the above policies of Kent Dental Excellence and understand my responsibilities as a patient.**

**Patient Signature**_____ **Date**_____

KENT DENTAL
Excellence

Tim Ernoff, D.D.S.

FAMILY & COSMETIC DENTISTRY
610 W Meeker Street,
Suite #102, Kent, WA 98032
253.852.6080 / 253.852.6099 (fax)
253.852.0690 (spanish line)
info@kentdental.net

www.kentdental.net

## ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights of privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that this information can and will be used to:

- Provide and coordinate my treatment among a number of health providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers for my health care services.
- Conduct normal health care operations such as quality assessment and improvement activities.

I have been informed of my dental provider's Notices of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notices of Privacy Practices. I understand that my dental provider has the right to change the Notices of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patients Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependent family members also covered by this acknowledgement: _____

**Additional Disclosure Authority:**

| | | | |
|---|---|---|---|
| Any member of my immediate family | yes | no | |
| Spouse only | yes | no | Name: _____ |
| Other-specify | yes | no | Name: _____ |

---

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

_____ The patient refused to sign
_____ Communication barriers
_____ Emergency situations
_____ Other _____