ALTITUDE DENTAL

Patient Registration

Personal Information

Date _____

Patient Full Name _____ Preferred Name _____

Address _____ Home Phone (____) _____

_____ Work Phone (____) _____

City State Zip

Cell Phone (_____) _____

Date of Birth _____ Social Security Number _____

Email Address _____

How did you hear about us? _____

Emergency Contact

Name _____ Phone # _____ Relationship _____

Dental Insurance Information

Primary Insurance Co _____ Subscriber _____

Member ID _____ Subscriber Date of Birth _____

Employer _____ Subscriber Social Security # _____

Group Number _____ Patient Relationship to Insured _____

Secondary Insurance Co _____ Subscriber _____

Member ID _____ Subscriber Date of Birth _____

Employer _____ Subscriber Social Security # _____

Group Number _____ Patient Relationship to Insured _____

WE MUST HAVE A COPY OF YOUR INSURANCE CARD(S) ON FILE

I hereby assign to Altitude Dental any and all benefits from any insurer, third party or other protection maintained for my benefit, and authorize and direct that such benefits be paid directly to Altitude Dental for services provided by Altitude Dental I also authorize the release of any of my health information to any person or entity that is or may be responsible for payment for services rendered by Altitude Dental, including without limitation, insurers and third party payers. I understand that, regardless of insurance coverage, I am responsible for the balance of my account. All accounts are due and payable within 30 days. If I do not pay the balance in full within 60 days of the monthly billing date a finance charge may be added to the account.

Our providers value your time and request that you value theirs. For this reason, we ask that patients give us a minimum of 2 business days' (48 hours) notice to cancel or change an appointment. Appointments not kept, cancelled and/or rescheduled within 48 hours of the scheduled time will result in a charge of up to $50/hour schedule.

The above information is complete and accurate to the best of my knowledge and I understand and accept the information above.

_____ _____

Signature of Patient (*or Parent/Guardian*) Date

MEDICAL HISTORY

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that

What is your estimate of your general health?
(Please circle) EXCELLENT GOOD FAIR POOR

Are you under a physician's care now? (Please list Name and Speciality)	Yes No	If yes
Have you ever been hospitalized or had a major operation?	Yes No	If yes
Are you taking any medications, pills ,drugs or dietary supplements?	Yes No	If yes
Are you taking medication for weight management (i.e. fen-phen)?	Yes No	
Have you ever had a serious head or neck injury?	Yes No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	Yes No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	Yes No	If yes
Do you use any drugs recreationally?	Yes No	If yes
Alcohol Consumption? Amount? Frequency?	Yes No	If yes
Are you a smoker or do you use smokeless tobacco?	Yes No	
Are you experiencing frequent headaches?	Yes No	If yes

Are you allergic to any of the following?

Aspirin	Yes No	Penicillin	Yes No	Erythromycin	Yes No	Tetracycline	Yes No
Sulfa Drugs	Yes No	Local Anesthetic	Yes No	Fluoride	Yes No	Metals (nickel,gold,silver)	Yes No
Latex	Yes No	Codeine	Yes No				

Other Allergies not Listed above? Yes No If yes

ARE YOU:

Taking birth control pills?	Yes No	Nursing?	Yes No	Pregnant/Trying to get Pregnant?	Yes No	Considered a touchy person?	Yes No
Often unhappy or depressed?	Yes No	Often exhausted or fatigued?	Yes No				

DO YOU HAVE OR HAVE YOU EVER HAD:

AIDS/HIV Positive	Yes No	Alzheimer's Disease	Yes No	Anemia / Blood Disorder	Yes No	Angina	Yes No
Antidepressant Medication	Yes No	Arthritis	Yes No	Artificial Joint	Yes No	Asthma	Yes No
Autoimmune Disease	Yes No	Breathing Problems	Yes No	Bruise Easily	Yes No	Cancer	Yes No
Chemotherapy	Yes No	Cold Sores / Fever Blisters	Yes No	Contact Lenses	Yes No	Diabetes (HbA1c_____)	Yes No
Digestive Disorder	Yes No	Drug Addiction	Yes No	Emotional Problems	Yes No	Emphysema	Yes No
Epilepsy / Seizures	Yes No	Glaucoma	Yes No	Heart Problems	Yes No	Heart: Artificial Valve	Yes No
Heart: Pacemaker	Yes No	Hepatitis (type_____)	Yes No	Herpes	Yes No	High Blood Pressure	Yes No
Hives or Skin Rash	Yes No	Hormone Deficiency	Yes No	Jaundice	Yes No	Kidney Dialysis	Yes No
Liver Disease	Yes No	Neurologic Disorder	Yes No	Osteoporosis	Yes No	Prolonged Bleeding (INR>3)	Yes No
Prostate Problems	Yes No	Psychiatric problems	Yes No	Radiation Therapy	Yes No	Rheumatic or Scarlet Fever	Yes No
Shingles	Yes No	Sinus Trouble	Yes No	Sleep Apnea / Snoring	Yes No	STDs	Yes No
Stomach Ulcers	Yes No	Thyroid or Parathyroid Disease	Yes No	Tuberculosis	Yes No	Tumor/Abnormal Growth	Yes No

Have you ever had or are you currently being treated for any other illness not listed above? Yes No If yes

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____ How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____ How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
SMILE CHARACTERISTICS		
7. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
8. Have you ever whitened (bleached) your teeth? _____	☐	☐
9. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
10 Have you been disappointed with the appearance of previous dental work? _____	☐	☐
BITE AND JAW JOINT		
11. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
12. Do you / would you have any problems chewing gum? _____	☐	☐
13. Do you / would you have any problems chewing bagels, baguettes , protein bars, or other hard foods? _____	☐	☐
14. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
15. Are your teeth crowding or developing spaces? _____	☐	☐
16. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
17. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
18. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
19. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
20. Do you wear or have you ever worn a bite appliance? _____	☐	☐
TOOTH STRUCTURE		
21. Have you had any cavities within the past 3 years? _____	☐	☐
22. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
23. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
24. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
25. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
26. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
27. Do you frequently get food caught between any teeth? _____	☐	☐
GUM AND BONE		
28. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
29. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
30. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
31. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
32. Have you ever experienced gum recession? _____	☐	☐
33. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
34. Have you experienced a burning sensation in your mouth? _____	☐	☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

ALTITUDE
DENTAL

FINANCIAL POLICY

This is an agreement between Altitude Dental and the Patient/Responsible Party indicated on this form.

Patient Payment at Time of Service: Our promise to you is to provide an estimation of your payment portion for any and all treatment recommended. We will do our best to accurately estimate dental benefit for all procedures, but actual reimbursement may vary from the estimate. As a courtesy to you, we can send a preauthorization to your insurance company upon request; however this may delay the start of treatment. Payment of patient portion is due at the appointment for all treatment received that day.

Monthly Statements: If there is a portion due after insurance has paid, we will send you a statement. It will show each visit you were seen for, the payments made by your insurance company to those dates, any contractual adjustments, other adjustments if applicable, and finance charges, if any. For any balance paid the previous billing cycle, these will not appear on future statements.

Payment: Unless other arrangements are approved by us in writing, the balance on your statement is due. Account balances not paid by the due date on the statement will be considered past due and may inquire a finance charge.

Payment of patient portions may be made with the following:

- Cash, Check or Money Order
- Major Credit Cards (Visa, MasterCard, American Express, Discover)

Missed Appointments and Late Cancellations: Our providers value your time and request that you value theirs. All hygiene appointments not kept, cancelled, and/or rescheduled at least 48 BUSINESS hours prior to the scheduled appointment time will be charged $50.00/hour. All restorative appointments not kept, canceled, and/or rescheduled at least 48 BUSINESS hours prior to the scheduled appointment time will be charged $75.00/hour. For Monday appointments, scheduling changes must be made by the previous Wednesday. These charges cannot be billed to your insurance company and will be your responsibility. Missed appointment fees must be paid before scheduling for future appointments.

Patient Name (print) _____

Responsible Party (print) _____

Signature _____ Date _____

ALTITUDE
DENTAL

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 Altitude Dental. 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 performances 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.

Altitude Dental reserves the right to change the privacy practices currently 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 revision become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one by mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified blow. (I understand that the default is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone else unless otherwise allowed by HIPAA rules.)

Spouse only	Yes	No
Any member of my immediate family: (Spouse, Children, Children's Spouses)	Yes	No
Any member of my extended family: (Parents, Grandchildren)	Yes	No
Other:	Yes	No

Patient Name (print) _____

Signature _____ Date _____

ALTITUDE
DENTAL

6100 219th St. SW Suite 530 – Mountlake Terrace, WA 98043

STATEMENT OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principle concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and 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 or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to 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 (PHI)

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental offices under certain circumstances. We will not use your information for marketing or fundraising 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, emails and text messages unless you direct us otherwise. We will never use, disclose, sell, otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in 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 Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your person 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 any 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.