Patient Registration

Patient Name _____ Today's Date: _____

Mailing Address _____ Home Phone: _____

City_____ State_____ Zip: _____ Work Phone: _____

Email: _____ Cell Phone: _____

Birth Date: ___/___/_____Age:_____ SSN: _____ Sex: Male Female

Marital Status: Single Married Widowed Divorced Spouses Name: _____

Emergency Contact: _____ Phone Number: _____

Employer: _____

How did you hear about our office? _____

Responsible Party:

Name: _____ Relationship to Patient _____

Mailing Address: _____ Home Phone: _____

City: _____State:_____ Zip: _____ Cell Phone: _____

Employer: _____

Social Security: _____Birth Date: _____ /_____ /_____

Driver's License: _____ Custodial Parent: Yes No Other or N/A

Dental Insurance Information:

PRIMARY INSURANCE: _____

Employer: _____

Subscriber's Name: _____

ID# or SS#: _____

DOB: _____ Group# _____

SECONDARY INSURANCE: _____

Employer: _____

Subscriber's Name: _____

ID# or SS#: _____

DOB: _____ Group# _____

Patient Signature (parent if minor):_____Date:_____

HEALTH HISTORY

Name:	**SEX:** □ M □ F
Today's Date:	**DOB:**

Reason for your visit today:		
Date of last dental visit:		
Last dental cleaning: Previous Dentist:		
How often do you have dental exams?		
Do you have any dental problems now? Explain:		
How often do you brush your teeth?		
How often do you floss?		
What other dental aid do you use? (Interplak, toothpick, etc.)?		
Have you ever used or are you currently using topical fluoride?	□ Yes	□ No

ARE ANY OF YOUR TEETH SENSITIVE TO:		
Hot or cold?	□ Yes	□ No
Sweets?	□ Yes	□ No
Biting or Chewing?	□ Yes	□ No
Have you noticed any mouth odors or bad taste?	□ Yes	□ No
Do you frequently get cold sores, blisters, or any other oral lesions?	□ Yes	□ No
Do your gums bleed?	□ Yes	□ No
Have your parents experienced gum disease or tooth loss?	□ Yes	□ No
Have you noticed any loose teeth or change in your bite?	□ Yes	□ No
Does food tend to become caught in between your teeth? If so where?	□ Yes	□ No

DO YOU:		
Clench or grind your teeth?	□ Yes	□ No
Bite your lips or cheeks regularly?	□ Yes	□ No
Hold foreign objects with your teeth? (pencils, pipe, etc.)?	□ Yes	□ No
Mouth breathe while awake or asleep?	□ Yes	□ No
Have tired jaws, especially in the morning?	□ Yes	□ No
Snore or have any other sleep disorders?	□ Yes	□ No
Smoke/chew tobacco or use tobacco products?	□ Yes	□ No

HAVE YOU EVER HAD:		
Orthodontic treatment?	□ Yes	□ No
Oral surgery?	□ Yes	□ No
Periodontal treatment?	□ Yes	□ No
Your teeth ground or the bite adjusted?	□ Yes	□ No
A bite plate or mouth guard?	□ Yes	□ No
A serious injury to the mouth or head?	□ Yes	□ No

HAVE YOU EXPERIENCED:		
Clicking or popping of the jaw?	□ Yes	□ No
Pain? (joint, ear, side of face)	□ Yes	□ No
Difficulty in opening or closing the mouth?	□ Yes	□ No
Headaches, neck aches or shoulder aches?	□ Yes	□ No

DENTAL HISTORY:		
Do you feel nervous about having dental treatment?	□ Yes	□ No
Have you ever had an upsetting dental experience?	□ Yes	□ No
Have you ever been told to take pre-medication prior to dental treatment?	□ Yes	□ No
Would you like to replace your silver fillings?	□ Yes	□ No
Would you like to keep all of your teeth all your life?	□ Yes	□ No
Are you satisfied with your teeth's appearance?	□ Yes	□ No

MEDICAL HISTORY:		
Physician's Name:	Phone number:	
Have you taken any medication or drugs during the last two years?	□ Yes	□ No
If yes, please list name and dosage:		
Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosages of aspirin?	□ Yes	□ No
If yes, please list name and dosage:		
Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates?	□ Yes	□ No
If yes, please list name and dosage		
Are you aware of having an allergic (or adverse) reaction to any substance or medication	□ Yes	□ No
If yes, please specify:		
Have you been a patient in the hospital during the past five years?	□ Yes	□ No
Have you lost or gained more than 10 pounds in the past year?	□ Yes	□ No
Do you have or have you had any disease, condition, or problem not listed?	□ Yes	□ No
WOMEN: Are you pregnant or think you could be?	□ Yes	□ No
Do you use birth control pills?	□ Yes	□ No

HAVE YOU EVER HAD OR DO YOU HAVE:

Ulcers	□ Yes	□ No
Diabetes	□ Yes	□ No
Thyroid Problems	□ Yes	□ No
Glaucoma	□ Yes	□ No
Contact Lenses	□ Yes	□ No
Emphysema	□ Yes	□ No
Chronic Cough	□ Yes	□ No
Tuberculosis	□ Yes	□ No
Asthma	□ Yes	□ No
Hay Fever/Allergy/Hives	□ Yes	□ No
Latex Sensitivity	□ Yes	□ No
Sinus Trouble	□ Yes	□ No
Radiation Therapy	□ Yes	□ No
Chemotherapy	□ Yes	□ No
Tumors	□ Yes	□ No

Heart (Surgery, Disease, Attack)	□ Yes	□ No
Chest Pain	□ Yes	□ No
Congenital Heart Disease	□ Yes	□ No
Heart Murmur	□ Yes	□ No
High/low Blood Pressure	□ Yes	□ No
Mitral Value Prolapse	□ Yes	□ No
Artificial Heart Value/Pacemaker	□ Yes	□ No
Rheumatic Fever	□ Yes	□ No
Arthritis/Rheumatism	□ Yes	□ No
Cortisone Medicine	□ Yes	□ No
Swollen Ankles	□ Yes	□ No
Stroke	□ Yes	□ No
Diet (Special/Restricted)	□ Yes	□ No
Artificial Joints (hip, knee, etc.)	□ Yes	□ No
Kidney Trouble	□ Yes	□ No

Hepatitis A B C (circle)	□ Yes	□ No
Venereal Disease	□ Yes	□ No
AIDS/HIV Positive	□ Yes	□ No
Cold Sores/Fever Blisters	□ Yes	□ No
Blood Transfusion	□ Yes	□ No
Hemophilia	□ Yes	□ No
Sickle Cell Disease	□ Yes	□ No
Bruises Easily	□ Yes	□ No
Liver Disease/Yellow Jaundice	□ Yes	□ No
Neurological Disorders	□ Yes	□ No
Epilepsy or Seizures	□ Yes	□ No
Fainting or Dizzy Spells	□ Yes	□ No
Nervous/Anxious	□ Yes	□ No
Psychiatric/Psychological Care	□ Yes	□ No
Cancer	□ Yes	□ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature: _____ Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Kelley Fisher, DDS, PLLC
22620 SE 4th St, Ste 220
Sammamish, WA 98074
425-392-1256

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

❑Provide and coordinate my treatment among a number of health care 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 by my dental provider's Notice of Privacy Practices, that contain 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 Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above to obtain a current copy of the Notice 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.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

For Office Use Only:

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

❑The patient refused to sign
❑Communication barriers
❑Other

Cancellations

Please give our office **48 hour notice** if you need to reschedule your appointment. Appointments rescheduled **after** that period will incur a charge of **the full appointment price** for hygiene appointments, and **patient portion** for appointments with Dr Fisher. By chance, if a scheduled appointment is missed, the same charge will incur. Your insurance company will not cover cancellation charges.

Thank you for your commitment to our practice and we promise to ensure excellent and timely care to you, your family, and friends.

Insurance Information

We are a participating provider with most dental insurance companies and maintain a "preferred provider" status with Aetna, Premera Blue Cross and Regence. As a courtesy we will file your insurance claims for you and accept assignment of benefit. Please maintain a copy of your plan benefits and alert us as to any changes. Your insurance policy is an agreement between your employer and the insurance company. While we will work closely to maximize your insurance coverage, every plan is uniquely different and plans change constantly. It is not possible for us to know the various clauses and individualities of every plan. Because of this, we can only provide an estimate for services rendered. For the most accurate estimate, please consult with the director of your plan. Should your insurance company pay less than expected, you will be responsible for the balance. If your insurance company pays more than we estimated, you will receive a refund. Please feel free to ask a financial coordinator if you have any questions about the cost of care.

I have read and understood the Billing, Credit Card on File and Insurance Policies for the practice of Kelley Fisher DDS, PLLC.

Photographic Release

In our office we like to photograph our patients to aid in proper diagnoses. Dr. Fisher also uses these photographs to teach other dentist and design beautiful smiles. In addition, we are proud of the work we do and like to use our own work to show other patients our beautiful results.

I _____, hereby authorize Dr. Kelley Fisher to take photographs, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, advertising (including website publication, newspaper, magazines, phone books, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication or a part of a demonstration, my name or other identifying information will be kept confidential.

Patient Name (Print): Relationship to Patient:

_____ _____

Patient Signature/Guardian: Date:

_____ _____

Financial Agreement

Billing & Insurance

We make every effort to provide you with the finest care and the most convenient financial options. In the interest of both medicine and good business, we believe it's the best to establish a fair financial policy to avoid any misunderstandings later. DO NOT hesitate to ask questions about the cost of your dental treatment. You have a right to know and understand our charges as well as your own insurance benefits. As a result we have adopted the following financial policies:

Fee & Payment Policy

A written estimate will be provided for you on all treatment plans. Estimated **patient portion** is required to reserve a day with the Doctor for all complex restorative and cosmetic treatment, regardless of insurance coverage.

1. Payment of the estimated **patient portion** is due at scheduling the appointment. We accept Visa, MasterCard, and American Express. We also offer Care Credit, an interest free financing program 6-12 months. As a courtesy, Dr. Fisher pays the interest. Visit **www.carecredit.com**.
2. A **5% courtesy** discount is offered to our **uninsured** patients who pay by **cash** or **check**. Patients that have large cases and pay in full with cash or check (no credit cards) will also receive a **5% courtesy**.
3. Accounts over 60 days may be charged a 1.5% monthly fee.
4. Accounts over 90 days past due may be assigned to a collections company.

Credit Card & Billing Policy

As of January 1, 2018, Dr. Kelley Fisher will ask all clients to provide a debit or credit card to keep on file in our **secure** electronic medical records program. ***Your provider will collect any payments due at the time of service by credit card, check or cash.*** A client who wishes to change their credit card on file may do so by phone 425-392-1256 or at any dental visit.

I hereby authorize Dr. Kelley Fisher, DDS, to run my credit/debit card(listed below) for any balance I accrue for services provided. I understand my card will be run without prior notice to myself.

Credit Card Information:

Name on card:_____

Card #_____ Exp Date _____ Sec Code _____

Complete Billing Address: _____

_____

Authorized signature:_____ Date: _____

NOTICE OF PRIVACY PRACTICES

This notice describes how medial information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running our practice.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use our confidential information to remind you of an appointment by sending reminder postcards, emails, text messages and/or leaving messages at home, work, and/or cell. Any other uses and disclosures will be made only with your written authorization.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below.

- The right to request restrictions on certain uses and disclosures of protected health information from us by alternative means or at alternative locations.
- The right to request to received confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information.
- The right to request an amendment of your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We require by law to maintain the privacy or your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of February 01, 2005, and we are required to abide to the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the term of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the revised notice from this office. You have the right to file a formal, written complaint with us at the address below, or with the Department of Health and Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filling a complaint.

For more information about your Privacy Practices, please contact for more information about HIPPA or to file a complaint:

Kelley Fisher
22620SE 4th St, Ste 220
Sammamish, WA 98074

Office of Civil Rights
200 Independence Ave SW
Washington, D.C. 20201 877-696-6775

Occlusal Screening

Name _____ Date _____

Many people experience symptoms that they feel are “normal” or are caused by other things such as allergies and stress. Many of these symptoms can actually be related to a “bad bite” Please take a moment to look over the screening symptoms below. Please check the appropriate line if you are experiencing or have experienced any of these in the past. Please feel free to ask us any questions.

___Headaches

___ Migraines

___ TMJ Noise (popping or clicking)

___ Limited Opening

___ Ear Congestion

____ Vertigo

___ Tinnitus (ringing in the ears)

___ Tearing (of the eyes for no apparent reason)

___ Dysphagia (difficulty swallowing)

___ Loose teeth

___ Clenching/Bruxing/Grinding

___ Facial Pain

___ Retro- orbital pain (pain behind the ears)

___ Tender, sensitive teeth

___ Difficulty chewing

___ Snoring/Sleep Apnea

___ Cervical Pain (Sore neck muscles)

___ Postural Problems

___ Paresthesia of fingertips (tingling in arms, hands or fingers)

___ Tooth Thermal Sensitivity (hot and cold)

___ Sore Jaw Muscles Upon Waking

___ Dry Mouth

___ Trigeminal Neuralgia (facial sagging)

___ Bell’s Palsy

___ Nervousness/ Insomnia

Your Personal Smile Evaluation

Name: _____ Date: _____

When I see a picture of myself:

___ I wish my teeth were whiter

___ I wish I had a broader smile

My teeth are____ crowded ____crooked____uneven____overlapped

____ My teeth have rough edges

My gums show ____too much ____ not enough

____ My top teeth don't show enough

____ There is too much space between my teeth

____ I have discolored areas between my teeth

____ I am not totally please with my smile

____ I am interested in options available for enhancing my smile