WEDGWOOD DENTAL CENTER

Emily Shackelton, DDS
7337 35th Avenue NE • Seattle, WA 98115
ph 206.525.9110 *fax* 206.525.0955

Patient Registration

PATIENT NAME: (Last, First, Middle Initial)			DATE OF BIRTH:
ADDRESS:			SOCIAL SECURITY NO:
CITY, STATE, ZIP:			MARITAL STATUS: ☐ Single ☐ Married
HOME PHONE:	CELL PHONE:	WORK PHONE:	BEST CONTACT METHOD: ☐ Home ☐ Cell ☐ Work ☐ Email
PREFER: ☐ Morning Appointment ☐ Afternoon Appointment			RELATIONSHIP TO INSURED: ☐ Self ☐ Spouse ☐ Child
E-MAIL ADDRESS:			SEX: ☐ Male ☐ Female

Other members of your family seen by this office:

NAME:	DATE OF BIRTH:	SOCIAL SECURITY NO:
NAME:	DATE OF BIRTH:	SOCIAL SECURITY NO:

Who should be notified locally in case of emergency?

NAME:	PHONE:
ADDRESS:	

Whom may we thank for referring you? ☐ Insurance List ☐ Website ☐ Sign ☐ Dental Professional ☐ Other:

NAME:	PHONE:

Insurance Information:

PRIMARY COVERAGE		SECONDARY COVERAGE
SUBSCRIBER'S NAME:		SUBSCRIBER'S NAME:
DATE OF BIRTH:		DATE OF BIRTH:
INSURANCE COMPANY:		INSURANCE COMPANY:
SOCIAL SECURITY or ID NO.:		SOCIAL SECURITY or ID NO:
GROUP NUMBER:		GROUP NUMBER:
LOCAL NUMBER OR POLICY NO.:		LOCAL NUMBER OR POLICY NO.:
EMPLOYER:		EMPLOYER:
OCCUPATION:		OCCUPATION:
UPDATED ON:	SIGNATURE:	DATE:

INFORMED CONSENT

1. Examinations and X-Rays.
I understand that the initial visit will require radiographs in order to complete the examination, diagnosis and treatment plan. (Initials ________)

2. Drugs, Medications, and Sedation.
I have been informed and understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction). They may cause drowsiness and lack of awareness and coordination, which can be increased by the use of alcohol or other drugs. I understand and fully agree not to operate any vehicle or hazardous device for at least 12 hours, or until fully recovered from the effects of the anesthetic, medications and drugs that may have been given me in the office for my care. I understand that failure to take medication as prescribed for me in the manner prescribed may offer risks of continued or aggravated infection and pain, and potential resistance to effective treatment of my condition. I understand that antibiotics can reduce the effectiveness of oral contraceptives. (Initials ________)

3. Changes in Treatment Plan. I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary. (Initials ________)

4. Temporomandibular Joint Dysfunction (TMD). I understand that symptoms of popping, clicking, locking and pain can intensify or develop in the joint of the lower jaw (near the ear) subsequent to routine dental treatment, wherein the mouth is held in the open position. Although symptoms of TMD associated with dental treatment are usually transitory in nature and well tolerated by most patients, I understand that should the need for treatment arise, then I will be referred to a specialist for treatment, the cost of which is my responsibility. (Initials ________)

NAME (PRINTED):	SIGNATURE:	DATE:
DOCTOR:	WITNESS:	

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Dental Health History

	Yes	No
Are you apprehensive about dental treatment?	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily?	☐	☐
Do you wear dentures?	☐	☐
Does food catch between your teeth?	☐	☐
Do you have any difficulty in chewing your food?	☐	☐
Do you chew on only one side of your mouth?	☐	☐
Because of pain?	☐	☐
Do your gums bleed easily?	☐	☐
Do your gums bleed when you floss?	☐	☐
Do your gums feel swollen or tender?	☐	☐
Have you ever noticed slow-healing sores in or around your mouth?	☐	☐
Are your teeth sensitive?	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids?	☐	☐
Cold foods or liquids?	☐	☐
Sours?	☐	☐
Sweets?	☐	☐
Do you take fluoride supplements?	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
Do you prefer to save your teeth?	☐	☐
Do you want complete dental care?	☐	☐

	Yes	No
How often do you brush? ____________________		
How often do you floss? ____________________		
Does your jaw make noise so that it bothers you or others?	☐	☐
Do you clench or grind your jaws frequently?	☐	☐
Do your jaws ever feel tired?	☐	☐
Does your jaw get stuck so that you can't open freely?	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears?	☐	☐
Do you have any jaw symptoms or headaches upon waking in the morning?	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing?	☐	☐
Do you take medications or pills for pain or discomfort (pain relievers, muscle relaxants, antidepressants)?	☐	☐
Do you have temporomandibular (jaw) disorder (TMD)?	☐	☐
Do you have pain in the face, cheeks, jaws, joints throat or temples?	☐	☐
Are you unable to open your mouth as far as you want?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you had a blow to the jaw (trauma)?	☐	☐
Are you a habitual gum chewer or pipe smoker?	☐	☐

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Medical Health History

Do you or have you had any of the following:	Yes	No
Heart Problems	☐	☐
Chest Pain	☐	☐
Shortness of breath	☐	☐
Blood pressure problem	☐	☐
Heart murmur	☐	☐
Heart valve problem	☐	☐
Taking heart medication	☐	☐
Rheumatic fever	☐	☐
Artificial heart valve	☐	☐
Blood Problems	☐	☐
Easy bruising	☐	☐
Frequent nosebleeds	☐	☐
Abnormal bleeding	☐	☐
Blood disease (anemia)	☐	☐
Ever require a blood transfusion	☐	☐
Allergy Problems	☐	☐
Hay fever	☐	☐
Sinus problems	☐	☐
Skin rashes	☐	☐
Taking allergy medication	☐	☐
Asthma	☐	☐
Intestinal Problems	☐	☐
Ulcers	☐	☐
Weight gain or loss	☐	☐
Special diet	☐	☐
Constipation/Diarrhea	☐	☐
Kidney or bladder problems	☐	☐
Bone or Joint Problems	☐	☐
Arthritis	☐	☐
Back or neck pain	☐	☐
Joint replacement (e.g. total hip, pins, or implants)	☐	☐
Fainting Spells, Seizures or Epilepsy	☐	☐
Strokes	☐	☐
Frequent or severe headaches	☐	☐
Thyroid problems	☐	☐
Persistent cough or swollen glands	☐	☐
Premedications required by physician	☐	☐
Cancer/Tumor	☐	☐

Are you allergic, or have you reacted adversely to any of the following?

	Yes	No
Local anesthetics (“Novocaine”)	☐	☐
Penicillin or other antibiotics	☐	☐
Sulfa drugs	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐
Aspirin, Acetaminophen or Ibuprofen	☐	☐
Codeine, Demerol or other narcotics	☐	☐
Reaction to metals	☐	☐
Latex or rubber dam	☐	☐
Other	☐	☐

Notes: ______________________________

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	Yes	No
Diabetes	☐	☐
Urinate more than 6 times a day	☐	☐
Thirsty or mouth is dry much of the time	☐	☐
Family history of diabetes	☐	☐
Tuberculosis or other respiratory disease	☐	☐
Do you drink alcohol?	☐	☐
If so, how much? ______________		
Do you smoke?	☐	☐
If so, how much? ______________		
Hepatitis, jaundice or liver trouble	☐	☐
Herpes or other STD	☐	☐
HIV-positive/AIDS	☐	☐
Glaucoma	☐	☐
Do you wear contact lenses?	☐	☐
History of head injury?	☐	☐
Epilepsy or other neurological disease?	☐	☐
History of alcohol or drug abuse?	☐	☐
Do you have any disease, condition or problem not listed previously that you feel we should know about?	☐	☐

If so, please describe:

____

____

During the past 12 months, have you taken any of the following?

	Yes	No
Antibiotics or sulfa drugs	☐	☐
Anticoagulants (e.g., Coumadin)	☐	☐
High blood pressure medicine	☐	☐
Tranquilizers	☐	☐
Insulin, Orinase or similar drug	☐	☐
Aspirin	☐	☐
Digitalis or drugs for heart trouble	☐	☐
Nitroglycerin	☐	☐
Cortisone (steroids)	☐	☐
Natural remedies	☐	☐
Nonprescription drug/supplements	☐	☐

Other:

____

____

Women

	Yes	No
Are you taking contraceptives or other hormones?	☐	☐
Are you pregnant?	☐	☐
If so, expected delivery date: __________		
Are you nursing?	☐	☐
Have you reached menopause?	☐	☐
If so, do you have any symptoms?	☐	☐

Notes: ______________________________

____

____

Patient/Parent Signature: ______________________________

Dentist Initials: ______________________________

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7337 35th Ave NE
Seattle, WA 98115
Tel: 206.525.9110
Fax: 206.525.0955

E-mail: info@wdcseattle.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ____, hereby authorize:

Name of practice or doctor: ______________________________________
Address: ______________________________________
____
Phone and fax number: ______________________________________
E-mail address: ______________________________________

To release information contained in my dental records to:

Dr. Emily Shackelton
Wedgwood Dental Center
7337 35th Ave NE
Seattle, WA 98115

206.525.9110
info@wdcseattle.com

Please email any x-ray's from the last 5 years and any other information that would be useful for future treatment.

Sincerely,

____
(Full Name)

____ ____________________
(Signature) **(Date)**

STATEMENT OF PRIVACY PRACTICES

WEDGWOOD DENTAL CENTER

Our office is dedicated to protecting 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 principal 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 offices 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 HEALTHCARE 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 HEALTHCARE 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 or fund-raising 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 unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the 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 personal 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 an 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.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Wedgwood Dental Center. 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. The Statement of Privacy Practices is also posted in the facility.

Wedgwood Dental Center 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 revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be 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 below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, protected health information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature:

Patient's personal representative: (Please Print):

Personal Rep's signature:

Representative's Phone Number:	**Date:**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided:**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	

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Appointment Guidelines

Rescheduling Your Appointment:

We pre-plan and prepare for your visit. Your appointment time has been reserved especially for you.

- Should any scheduling changes be required, **we require at least 2 business days advance notice to avoid a $75 cancellation fee.**

Courtesy Reminder Calls:

We consider all appointments confirmed when they are made. As a courtesy, we make every effort to remind patients by telephone or email prior to their appointment but please do not depend on this courtesy. We have found that with the popular use of answering machines, cell phones and voice mail, some of our patients may not receive these reminder calls.

- **If we are unable to speak with you directly, your appointment card will serve as confirmation and implies your obligation to be present at that prearranged date and time.**

By initialing this section and signing below, you indicate that you understand and agree to these appointment guidelines.

Initials ________

Insurance Guidelines

We are glad you have dental insurance to help you with partial assistance in affording your dental care. As a courtesy, we are happy to assist you in filing the necessary forms to help you receive the full benefits of your dental insurance coverage at no additional cost. Dental insurance is different than most medical insurance plans and it is important to be aware of the following:

- **Insurance is an agreement between you and your insurance company.** The insurance relationship constitutes an agreement between the carrier, the employer, and the patient. Our dental office is not a party to that contract. As such, we can make no guarantee of estimated coverage or payment.
- **Full dental fees are not always covered.** Insurance companies base the amounts they pay on restrictive fee schedules, regardless of what the actual fee may be. Our fees are often, but not necessarily, covered in full by the maximum allowance determined by your carrier.
- **Not all your care may be covered.** Not all dental services that are necessary for proper dental health are a covered benefit in all contracts. This depends on the kind of plan your employer has purchased.
- **Deductibles and Co-payments must be collected.** Deductibles and co-payments are built into most plans and their required payment is strictly regulated by state law. Your Employee Benefits Director can usually help you become familiar with your plan and its restrictions.

Here's What We Promise To Do:

1. Complete insurance claim forms and submit to your carrier within 48 hours of treatment.
2. Use current American Dental Association coding for correct reporting of procedures.
3. Accept direct payment from your carrier and keep track of balances.
4. If necessary, re-file your insurance a second time within a 30-90 day period.

Your Responsibilities Will Be:

1. Pay fees not covered by your plan at the time of treatment or as otherwise arranged
2. Provide our office with necessary information concerning your insurance coverage to allow correct filing of claims
3. To understand that your plan is a contract between you, your employer, and the insurance carrier. Our office will do all we can to facilitate claims payment, but we do not have the power to force your insurance company to pay.
4. To pay any account balance not paid by insurance after 60 days and after 2 billing attempts.

Initials ________

I hereby authorize payment of the insurance benefits otherwise payable to me to be made directly to this dental office. I understand that any insurance coverage estimate given to me by this office is not a guarantee of actual insurance payment. I also understand that I am ultimately responsible for all charges incurred for dentistry performed upon myself or my dependents in this dental office. I authorize release of my dental/medical histories and other information about my dental treatment to third party payers.

____ ____________

Patient or Insured ***Date***

____ ____________

Dental Office Representative ***Date***