

COOK FAMILY DENTISTRY

321 4TH St SE
Auburn, WA 98002

Welcome to our office

PATIENT REGISTRATION

Patient Name: Mr Mrs Ms Dr _____ Preferred Name: _____
Gender: M F Other: _____ Date of Birth: _____ Age: _____ Social Security #: _____
Home #: _____ Work #: _____ Cell #: _____ Best time to call: _____
Email address: _____ Preferred method of contact: _____
Address: _____ City: _____ Zip: _____
Marital status: _____ Employer: _____ Occupation: _____

Whom may we thank for referring you? _____
Other family members seen by us: _____
Spouse's name: _____ Date of Birth: _____ Employer: _____

Person financially responsible for this account: _____
With whom may we discuss dental treatment and billing obligations? _____

PRIMARY INSURANCE

Insurance Company: _____ Address: _____ Phone #: _____
Subscriber's name: _____ Patient relation to subscriber: _____
Subscriber's date of birth: _____ Subscriber's Social Sec #: _____ ID #: _____
Subscriber's employer: _____ Group # (Plan, Local, or Policy #) _____

SECONDARY INSURANCE

Insurance Company: _____ Address: _____ Phone #: _____
Subscriber's name: _____ Patient relation to subscriber: _____
Subscriber's date of birth: _____ Subscriber's Social Sec #: _____ ID #: _____
Subscriber's employer: _____ Group # (Plan, Local, or Policy #) _____

EMERGENCY CONTACT

Name: _____ Phone #: _____ Relation to patient: _____

DENTAL HISTORY

Reason for today's visit: _____
Date of last dental visit: _____ Date of last dental X-rays: _____
Do you have any fear of the dentist? (about 50% of adults do!) _____

Please circle any that apply to you:

- | | | |
|---------------------------|-------------------------------|-------------------------|
| Bad breath | Clenching/grinding | Loose teeth or fillings |
| Bleeding gums | Dry Mouth | Orthodontics/braces |
| Blisters on lips or mouth | Food collection between teeth | Periodontal treatment |

Do you have problems with your jaw?(circle any that apply) Yes No Pain Clicking Popping

Which side? Right Left Both

Do you use tobacco? Chewing Pipe Cigar Cigarette Other (please describe): _____

Do you have sensitivity? Yes No Sweets Pressure/Biting Temperature: Hot Cold Other: _____

HEALTH HISTORY

Physician's name: _____ City: _____ Phone: _____

Pharmacy: _____ City: _____ Phone: _____

Please circle any that apply to you:

AIDS/HIV	Diabetes: Type I Type II	Shortness of Breath
Anemia	Emphysema	Sinus Trouble: Right Left
Arthritis	Epilepsy	Stroke
Artificial Heart Valves	Heart Problems	Swollen Gums
Asthma	Hepatitis: Type _____	Swollen Feet/Ankles
Bleeding Abnormally	Joint Replacement	Swollen Neck Glands
Blood Pressure: High Low	Kidney Disease	Tumor or Growth on Neck/Head
Cancer	Liver Disease	Ulcer or Acid Reflux
Congenital/birth defect of heart	Pacemaker	Weight loss. (unexplained)
Cough, persistent or bloody	Radiation to Head/Neck	Other:

Do you have frequent headaches? Morning Daytime Random times Migraines No Other: _____

Have you had a sleep study? Yes No Results of sleep study: _____

CURRENT MEDICATIONS (please list ALL medications)

Please tell us of any medication changes at every appointment. If you take multiple medications, we would be happy to photocopy a list for your chart.

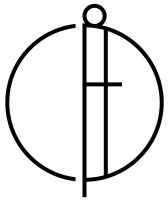
ALLERGIES (please list ALL allergies, including those to foods and substances like latex)

I understand that this information is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

Signature

Date

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.



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Patient Name: _____ Preferred Name: _____

Clenching/Grinding Questionnaire

Do you experience any of the following symptoms?

- Morning headaches: Yes No Sometimes
- Morning jaw soreness: Yes No Sometimes
- Morning joint soreness (TMJ): Yes No Sometimes
- Morning neck aches: Yes No Sometimes
- General sensitivity to cold/biting: Yes No Sometimes
- Fractured teeth: Yes No Sometimes
- Broken fillings: Yes No Sometimes
- Broken crowns: Yes No Sometimes
- Loose teeth: Yes No Sometimes
- Drifting teeth: Yes No Sometimes
- Area that traps food: Yes No Sometimes

Clenching and grinding causes the following:

- Flattened and/or chipped front teeth Flattened back teeth
- Fractured teeth, fillings, crowns Food trapping
- Loose teeth Recession of the gums
- Abfraction (missing enamel near the gum line)
- Sensitivity, especially at the gumline Large bony growths (tori)

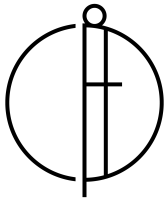
Ask us today if you are interested in more information about Botox/Xeomin for clenching/grinding. Clenching can cause teeth to shift, opening gaps between teeth and trapping foods. This gap can come and go. Such gaps can often be corrected with an orthodontic retainer, but without use of a nightguard, the gap can return.

Patients who have the above signs and symptoms are recommended to use a night guard to protect their teeth, fillings, and crowns and to help prevent the above signs and symptoms.

Patients who do not use a night guard when recommended are responsible for all replacement costs of broken fillings and crowns, regardless of how old the fillings and crowns are.

Signature

Date



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Invisalign Questionnaire

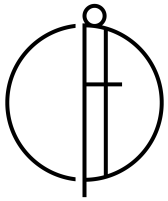
How happy are you with your smile?

Circle one:

1. Perfect. I wouldn't change it.
2. Not perfect, but I wouldn't change it.
3. There are a few things that I would like to improve.
4. I am not comfortable with my smile.

What would you change?





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Patient Name: _____ Preferred Name: _____

Epworth Sleepiness Scale

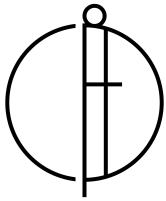
The Epworth Sleepiness Scale is used to determine the level of daytime sleepiness. A score of 10 or more is considered sleepy. A score of 18 or more is very sleepy. If you score 10 or more on this test, you should consider whether you are obtaining adequate sleep and/or need to see a sleep specialist. These issues should be discussed with your care provider.

Use the following scale to choose the most appropriate number for each situation:

- 0 = would never doze or sleep
- 1 = slight chance of dozing or sleeping
- 2 = moderate chance of dozing or sleeping
- 3 = high chance of dozing or sleeping

Fill in your answers and see where you stand.

Situation	Chance of Dozing or Sleeping
Sitting and reading	
Watching TV	
Sitting inactive in a public place	
Being a passenger in a motor for an hour or more	
Lying down in the afternoon	
Sitting and talking to someone	
Sitting quietly after lunch (no alcohol)	
Stopped for a few minutes in traffic while driving	
Your Epworth Score (add up the scores in the right column)	



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Financial Policy

At Cook Family Dentistry we take great pride in offering our patients a variety of treatment options that meet their unique needs and budgets.

Treatment Options and Estimates

Based on the information we have received from your insurance company, we will provide you with an estimate of treatment related to proposed treatment options before treatment is provided.

Late Cancellation/Missed Appointment

We consider your appointments confirmed and reserved for you on the day they are scheduled. As a courtesy, we will remind you of your appointment 2 business days prior to your appointment by phone, text or email. We understand that events may arise that may require a patient to change or reschedule an appointment. We require changes to appointments to be made by phone **2 business days** prior to the appointment time. A **\$50** missed appointment fee will be applied to your account for any cancelled or missed appointments without a minimum of 2 business days. A **\$250** charge for a missed 3-hour appointment.

Dental Insurance

As a courtesy to our patients, our team will work with your dental insurance carrier to provide a good faith estimate of insurance coverage. We ask that you pay the estimated patient responsibility or copay at the time of service. If there is a portion owing after payment from insurance has been received, it is the patient's responsibility to pay the remaining balance. Any overpayments will be refunded. Fees and insurance coverages are estimates only. **By signing this agreement I understand that Cook Family Dentistry is not responsible for non-payment of benefits by my insurance company due to terms and clauses of my policy or denials. I as a patient or responsible party, am fully responsible for all charges incurred whether I have insurance or not.** All balances are due within 30 days of the service.

Payment and Financing Options

For your convenience we accept the following methods of payment; **Cash, Check, Money Order ,Visa , MasterCard, Discover, American Express, HAS & FSA**

For Patients without Dental Insurance

For patients without dental insurance, you may qualify for our Wellness Plan. Please ask one of our team members for further information. Without the Wellness Plan, we offer a 5% discount when services are paid in full by cash, check or credit card. If a check or transaction is returned due to insufficient funds, a \$50 administrative fee will be assessed and the 5% discount will be reversed.

By checking this box I give permission for Cook Family Dentistry to use images of my teeth and/or smile (not face) on their website and/or other informational materials. I understand that my name, face or any identifying information will never be disclosed. In the event that Cook Family Dentistry ever desires to use my full facial image, I would give separate consent and would be allowed to approve any images before use.

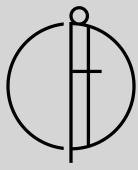
I have read and understand the Financial Arrangement Policy and agree to the terms described therein. I understand that I will be personally responsible for any fees incurred at Cook Family Dentistry. If a check or transaction is returned due to insufficient funds, a \$50 administrative fee will be assessed and any discounts received will be reversed.

Patient Name (please print)

Relation to Patient

Signature

Date



Cook Family Dentistry

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 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.

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 _____. 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.

_____ 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, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse Only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other: (please describe)	<input type="checkbox"/> YES	<input type="checkbox"/> NO

Name of Patient (please print): _____

Patient Signature: _____

Patient's Personal Representative (please print): _____

Personal Representative's Signature: _____

Representative's Phone Number: _____ Date: _____

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained

Provided Prior to Treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date Statement Provided: _____
Reason for not obtaining patient Signature	<input type="checkbox"/>	Needed more time to review statement	
	<input type="checkbox"/>	Wanted to consult another person before signing	
	<input type="checkbox"/>	Physically unable to sign	
	<input type="checkbox"/>	No reason offered	
	<input type="checkbox"/>	Other:	