COOK FAMILY DENTISTRY
321 4TH St SE
Auburn, WA 98002

Welcome to our office

PATIENT REGISTRATION

Child's Name: _____ Preferred Name: _____

Gender: M F Other: _____ Date of Birth: _____ Age: ___ School District/Grade: _____

Address: _____ City: _____. Zip: _____

Sports/Hobbies: _____

How did you hear about us or whom may we thank for referring you? _____

Who is accompanying your child today? _____ Do you have legal custody of this child? Yes No

Person financially responsible for this account: _____

With whom may we discuss dental treatment and billing obligations? _____

MOTHER'S INFORMATION

Name: _____ stepmother guardian Birthdate: _____

Employer: _____ Job title: _____

Home #: _____ Cell #: _____ Work#: _____ ext_____

FATHER'S INFORMATION

Name: _____ stepfather guardian Birthdate: _____

Employer: _____ Job title: _____

Home #: _____ Cell #: _____ Work#: _____ ext_____

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: _____

Does your child have a fear of the dentist? _____

Please circle any that apply to your child:

Bad breath	Clenching/Grinding	Injury to head or neck
Bleeding gums	Discoloration	Loose teeth or fillings
Blisters on lips or mouth	Dry Mouth/Mouth Breathing	Orthodontics/braces
Cavities	Food collection between teeth	Thumb Sucking
Cigarette/chewing tobacco	Injury to face or mouth	Other:

Does your child have problems with their jaw?(circle any that apply) Yes No Pain Clicking Popping

Which side? Right Left Both

Do they 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 your child:

Adenoidectomy	Cough, persistent or bloody	Swollen Gums
ADHD/ADD	Diabetes: Type I Type II	Swollen Neck Glands
Artificial Heart Valves	Epilepsy	Tonsillectomy
Asthma	Frequent Sore Throat	Trouble Sleeping
Autism Spectrum	Headaches	Tumor or Growth on Neck/Head
Bleeding Abnormally	Heart Problems	Reflux
Cancer	Hepatitis: Type _____	Weight loss. (unexplained)
Concussion	Radiation to Head/Neck	Other:
Congenital/birth defect of heart	Sinus Trouble: Right Left	

CURRENT MEDICATIONS (please list ALL medications)

Please tell us of any medication changes at every appointment.

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	Relation to Patient	Date

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

COOK FAMILY DENTISTRY
321 4TH St SE
Auburn, WA 98002

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	☐ 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: (please describe)	☐ YES	☐ 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?	☐ 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:	