Clear All Entries

urban smiles family dentistry

2936 eastlake ave e seattle, wa 98102

urbansmiles.com

206.325.1414

new patient information form

please bring to your first appointment

SECTION 1: GENERAL INFORMATION

TODAY'S DATE: 06/05/12

NAME: Last, First, Middle	☐ Male ☐ Female	SOCIAL SECURITY NUMBER

ADDRESS: Street or PO Box | City | State | Zip

PHONE NUMBERS: Home | Cellular | Work | Pager

E-MAIL | BIRTH DATE | BIRTH PLACE | ☐ Single ☐ Married ☐ Divorced/Separated

OCCUPATION	EMPLOYER	HOW LONG EMPLOYED

SECTION 2: PARENT OR GUARDIAN OF PATIENT (IF PATIENT IS UNDER 18 YEARS OF AGE) OR EMERGENCY CONTACT

NAME: Last, First, Middle	RELATIONSHIP TO PATIENT

PHONE NUMBERS: Home | Cellular | Work | Pager

ADDRESS: Street or PO Box | City | State | Zip

E-MAIL | OCCUPATION | EMPLOYER | HOW LONG EMPLOYED

SECTION 3: INSURANCE INFORMATION

SUBSCRIBER'S NAME: Last, First, Middle	DATE OF BIRTH	SOCIAL SECURITY OR SUBSCRIBER NUMBER

RELATIONSHIP TO PATIENT | EMPLOYER'S NAME | WORK PHONE | NAME OF INSURANCE COMPANY

GROUP OR PLAN NUMBER	FULL ADDRESS OF INSURANCE COMPANY

SECTION 4: SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

SUBSCRIBER'S NAME: Last, First, Middle	DATE OF BIRTH	SOCIAL SECURITY OR SUBSCRIBER NUMBER

RELATIONSHIP TO PATIENT | EMPLOYER'S NAME | WORK PHONE | NAME OF INSURANCE COMPANY

GROUP OR PLAN NUMBER	FULL ADDRESS OF INSURANCE COMPANY

SECTION 5: PERSON RESPONSIBLE FOR ACCOUNT

NAME: Last, First, Middle	RELATIONSHIP TO PATIENT	☐ Male ☐ Female	SOCIAL SECURITY NO.	DATE OF BIRTH

E-MAIL | ADDRESS: Street or PO Box | City | State | Zip

PHONE NUMBERS: Home | Cellular | Work | Pager

SECTION 6: GETTING TO KNOW YOU

What is the reason for your visit today? _____

Why did you start looking for a new dentist? _____

What did you like **most** about your previous dental visits? _____

What did you like **least** in your previous dental visits? _____

Please check the level of fear you have about dental visits (10 being the greatest fear):

☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

Please rank from 1-5, (1 being the most important) each of the following regarding your dental care:

Preventive Dental Health **Freedom From Pain** **Quality of Service** **Cost & Affordability** **Other** _____

WHOM MAY WE THANK FOR REFERRING YOU?

- ☐ Patient _____
- ☐ Website / Search Engine
- ☐ Phone book / yellow pages
- ☐ Street signage
- ☐ Other _____

_____

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medical / dental history form

please be accurate and thorough

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 you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? ◯ Yes ◯ No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? ◯ Yes ◯ No If yes, please explain: _____
Have you ever had a serious head or neck injury? ◯ Yes ◯ No If yes, please explain: _____
Are you taking any medications, pills, or drugs? ◯ Yes ◯ No If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux? ◯ Yes ◯ No _____
Are you on a special diet? ◯ Yes ◯ No _____
Do you use tobacco? ◯ Yes ◯ No
Do you use controlled substances? ◯ Yes ◯ No

Women: Are you

Pregnant/Trying to get pregnant? ◯ Yes ◯ No Taking oral contraceptives? ◯ Yes ◯ No Nursing? ◯ Yes ◯ No

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local Anesthetics

☐ Other If yes, please explain: _____

Do you have, or have you had, any of the following?

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Breathing Problem ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pace Maker ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No	Yellow Jaundice ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No	

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes, please explain: _____

Comments: _____

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 ✖_____ DATE _____

TODAY'S DATE: 06/05/12 **PATIENT BIRTH DATE:** **PATIENT NAME:**

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notice of information practices and patient acknowledgement

The Health Insurance Portability and Accountability Act of 1996 (**HIPAA**) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. **HIPAA** provides penalties for covered entities that misuse personal health information.

As required by **HIPAA**, 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 protected health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, or health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. Examples of this would include related care and treatment services by health care providers, scheduling surgery, other exams or appointments with other providers, calling in prescriptions and refills, consultation between health care providers relating to a patient for coordination of care and physician to staff discussions for coordination of care, and the referral of a patient for health care from one health care provider to another.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, related data processing, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health care operations** include the business aspects of running our practice on a daily basis, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

We reserve the right to update these practices at any time. The revised notice will be posted in our patient waiting areas and you will have the opportunity to request a paper or electronic copy of the revised notice from our staff, or by accessing our website.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to confirm your appointments or communicate with you in connection with care management or coordination. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to us:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to revoke it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

NOTICE OF INFORMATION PRACTICES PATIENT ACKNOWLEDGEMENT

I have received and understand the practice's *Notice of Information Practices* written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise those rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its *Notice of Information Practices* and to make changes regarding all protected health information resident at, or controlled by, this practice. If changes to the policy occur, this practice will provide me a revised Notice of Information Practices upon request.

✖ _____ _____

signature of patient, parent, or guardian date

TODAY'S DATE: 06/05/12 **PATIENT BIRTH DATE:** **PATIENT NAME:**

urban smiles family dentistry
2936 eastlake ave east seattle, wa 98102

disclosure authorization and mutual agreement to maintain privacy

Dr. Mironov and Urban Smiles Family Dentistry (*collectively labeled "Dentist"*) agree to maintain the privacy of our patients as outlined in this HIPAA form. The Dentist takes pride in being able to extend a greater degree of privacy than is required by HIPAA, state confidentiality mandates, and common law.

Federal and State privacy laws are complex. Unfortunately, some dental offices try to find loopholes around these laws. For example, **HIPAA** forbids dentists from receiving money for selling lists of patients or protected health information to companies to market their products or services directly to patients without authorization. Some dental practices, though, can lawfully circumvent this limitation by having a third party perform the marketing. While personal data is never technically in the possession of the company selling its products or services, the patient can still be targeted with unwanted marketing information. Dentist believes this is improper and may not be in the patient's best interest. Accordingly, Dentist agrees not to provide any list for marketing or be paid for selling patient lists or protected health information to any party for the purpose of marketing directly to patients. Regardless of legal privacy loopholes, Dentist will never attempt to leverage its relationship with Patient by seeking Patient's consent for marketing products for others.

In consideration for treatment and the above noted patient protection, Patient agrees to refrain from directly or indirectly publishing or airing commentary upon Dentist and his practice, expertise and/or treatment unless explicitly mandated by law. Publishing is intended to include attribution by name, by pseudonym, or anonymously. Dentist has invested significant financial and marketing resources in developing the practice. In addition, Patient will not denigrate, defame, disparage, or cast aspersions upon the Dentist; and will use all reasonable efforts to prevent any member of their immediate family or acquaintance from engaging in any such activity. Published comments on web pages, blogs, and/or mass correspondence, however well intended, could severely damage Dentist's practice.

Dentist feels strongly about Patient's privacy as well as the practice's right to control its public image and privacy. Both Dentist and Patient will work to prevent the publishing or airing of commentary about the other party from being accessed via internet, blogs, or other electronic, print, or broadcast media without prior written consent.

Finally, this Agreement shall be in force and enforceable (and fully survive) for a period of the longer of (a) five years from Dentist's last date of service to Patient; or (b) three years beyond any termination of the Dentist-Patient relationship. As a matter of office policy, Dentist is requiring all patients in its practice sign the Mutual Agreement to Maintain Privacy so as to establish that any anonymous or pseudonymous publishing or airing of commentary will be covered by this agreement for all Dentist's patients.

Patient and Dentist acknowledge that breach of this Agreement may result in serious, irreparable harm. In addition to compensation for consequential damages, Patient and Dentist agree to the right of equitable relief (including but not limited to injunctive relief). Should a breach of this Agreement result in litigation, the prevailing party in the litigation shall be entitled to reasonable costs, expenses, and attorney fees associated with the litigation.

Patient has been given the opportunity to ask questions and receive satisfactory and adequate explanations.

✖ _____ _____

signature of patient, parent, or guardian — date

I. Mironov DDS PLLC / Urban Smiles Family Dentistry

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the *Notice of Information Practices*, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below:

Any member of my immediate family ___yes ___no

Spouse ___yes ___no

Other _____ ___yes ___no

_____ _____

signature of patient, parent, or guardian — date

TODAY'S DATE: 06/05/12 **PATIENT BIRTH DATE:** **PATIENT NAME:**

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general financial agreement and policy acknowledgements

FINANCIAL AGREEMENT

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility before treatment begins. We desire to make dental treatment affordable to all our patients.

If you have dental insurance, we want you to receive the full benefit of it. Because we understand that dental insurance plays a role in helping many people defray some of the costs of dental care, we would like to share with you the following information about dental insurance.

Please understand that our responsibility is to provide you with the treatment that best meets your needs, and not try to match your care to insurance plans limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered, even though you may need those services.

In spite of your plan says, we have found that many plans actually pay less than what you might expect. The benefits your plan pays are largely determined by how much you and your employer pay in premiums. Our office staff will assist you in completing your insurance forms and verifying the coverage that your particular insurance plan provides. We are happy to submit your claims and help you to receive the maximum benefits that you are due. We accept assignment of your insurance payment, but please understand that we cannot accept responsibility for collecting an insurance claim, or for negotiating disputed claims. Patient is responsible for any applicable deductable amounts and the portion of fees that your insurance does not cover. Please be advised that although our staff will make every effort to accurately estimate what your insurance will pay, this does not, in any way, guarantee actual payment from your insurance company. You will be financially responsible for the account, should your insurance plan(s) not honor financial benefits for any procedures rendered.

I have read and understand the above financial agreement. Regardless of the insurance coverage, I am responsible for payment of all dental fees for myself and/or my dependants.

✖ _____ _____

signature of patient, parent, or guardian date

GENERAL CONSENT

I hereby authorize the doctor to perform any and all forms of treatment, medication, and therapy, that may be indicated in connection with rendering appropriate dental care and further authorize and consent to the doctor choosing and employing such assistance as he deems fit. I also understand that prior to treatment, a full explanation of the procedure(s) involved will be given by the doctor and/or his staff. I agree to pay for all services rendered by this office. I also consent to the use of periodic appointment reminder phone calls and appointment reminders sent via mail. I also understand that should my account become delinquent, my information may be released to a third party collection agency to assist with collecting fees associated with treatment rendered in this office.

✖ _____ _____

signature of patient, parent, or guardian date

APPOINTMENT POLICY AKCNOWLEDGEMENT

When you (or a family member) make an appointment, you are responsible for keeping that appointment. Our staff will remind you of your appointment in advance. If you would like to cancel or reschedule your appointment we simply ask for 48 hour advance notice. A message left on our answer machine is considered valid notice. There will be a $50 charge if you give notice less than 48 hours before your appointment or if you do not show up to your appointment without giving us notice.

I have read, understand and agree to abide by the above appointment policy.

✖ _____ _____

signature of patient, parent, or guardian date

Click here to print the forms (5 pages)

If you have completed filling out the forms, click above to print them out. Please read and sign the printed copy and bring it to your first appointment. After printing, please click below to clear the form of sensitive personal & medical information

Clear All Entries

TODAY'S DATE: 06/05/12 **PATIENT BIRTH DATE:** **PATIENT NAME:**

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transfer of records patient authorization and requestform

PATIENT INFORMATION

I hereby authorize you to use or disclose the information described below only for the purposes and parties described below.

Name of Patient _____

Date of Birth of Patient _____

Person Requesting Information _____

Relationship to patient _____

Information requested ☑ PANO ☑ FMX ☑ BWX

Other information _____

Please send information to:

ELECTRONICALLY

seattle@urbansmiles.com

MAIL / HARD COPIES

urban smiles family dentistry
2936 eastlake ave e
seattle, wa 98102

Information is being requested for the following purpose:

2nd opinion ____ Moving ____ Seeing other DDS ☐ Other ____

✖ _____ _____

signature of patient, parent, or guardian date