CREEKSIDE DENTAL

REGISTRATION FORM

Please Print

Today's date_____________________________

PATIENT INFORMATION

Patient's Last Name:_________________________________First:_____________________________Middle:____________________

Home Phone #:_________________Work #:_________________Cell #:_________________Email Address:_________________________

Street Address:_____________________________________City:___________________________State:___________Zip Code:__________

Martial Status: Single ☐ Mar ☐ Sep ☐ Widow ☐ Gender: Male ☐ Female ☐ Birth Date:________________Age:________________

Occupation:______________________________Employer:________________________________Social Security No:____________________

Person Responsible for Account:______________________________Address:______________________Home Phone #:_______________

Birthdate:_________________Social Security #:_________________Drivers License #:_________________Cell Phone #:_________________

REFERRED BY: ☐ Phone Book ☐ Location ☐ Patient (Name):____________________________ ☐ Other:_________________________

Person to Contact for Emergency:____Phone No:_________________________

INSURANCE INFORMATION

(Please give your insurance card to the receptionist)

Is This Patient Covered By Insurance? ☐ Yes ☐ No Do You Have Medicaid? ☐ Yes ☐ No

Name of Primary Insurance:____Group No:_______________Policy No:_______________

Subscriber's Name:____Subscriber's SS No:_______________Birthdate:_______________

Patient's Relationship To Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:____

Secondary Insurance (if applicable) Subscriber's Name:____________________________________Group No:_________Policy No:_________

Subscriber's Name:____Subscriber's SS No:_______________Birthdate:_______________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other:____

CONSENT

The undersigned hereby authorizes Doctor to take X-rays, study models, photographs or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated in connection with the above named patient. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for my dependents or myself is mine, due and payable at the time services are rendered unless financial arrangements have been made. I authorize my insurance benefits to be paid directly to the dental office. I also authorize the dental office or insurance company to release any information required for this claim. I understand that I am responsible for any fees not paid by insurance and that a credit report may be obtained if necessary. I understand that if I need to change an appointment time, a 24-hour notification is necessary.

Signature____Relationship to Patient____________________Date_________________

Patient, Parent or Guardian

Name:____Date of Birth:__________________________

PATIENT MEDICAL HISTORY: *CIRCLE*

1. Have you been under the care of a physician during the last two years? **YES NO**
   If Yes, please describe condition:____
   Physicians name____Phone________________________
2. Have you taken any medications/prescriptions during the past two years? **YES NO**
   If Yes, please list:____
   ____
3. Do you have any known allergies? **YES NO**
   If Yes, please list:____
4. Have you been hospitalized or had any surgery in the past 5 years? **YES NO**
   If Yes, please describe:____
5. If female, are you now pregnant? Due date?____ **YES NO**
   Are you currently nursing? **YES NO**

6. If you have had any of the following conditions, circle "Yes" & indicate <u>Month/Year</u>, if not circle "No".

Yes No AIDS/HIV	**Yes No** Diabetes	**Yes No** Hyper/Hypo Thyroidism
Yes No Alcohol Addiction	**Yes No** Dizzy/Fainting Spells	**Yes No** Jaundice/Liver Disease
Yes No Allergies - Seasonal	**Yes No** Drug Addiction	**Yes No** Kidney Trouble
Yes No Anemia	**Yes No** Dry Mouth	**Yes No** Mental/ Nervous Disorder
Yes No Anorexia/Bulimia	**Yes No** Emphysema/Bronchitis	**Yes No** Mitral Valve Prolapse____/____
Yes No Arthritis – OA or RA	**Yes No** Epilepsy/Seizures____/____	**Yes No** Osteoporosis/Bone Disease
Yes No Artificial Heart Valves____/____	**Yes No** Fibromyalgia	**Yes No** Prolonged Bleeding
Yes No Artificial Joints____/____	**Yes No** Heart Attack____/____	**Yes No** Psychiatric Treatment
Yes No Asthma	**Yes No** Heart Disease	**Yes No** Radiation Treatment____/____
Yes No Cancer/Tumors	**Yes No** Heart Murmur	**Yes No** Rheumatic Fever
Yes No Chemotherapy____/____	**Yes No** Heart Pacemaker	**Yes No** Sinus Trouble
Yes No Chest Pains	**Yes No** Heart Surgery____/____	**Yes No** Stroke____/____
Yes No Cold Sores	**Yes No** Herpes	**Yes No** Tuberculosis____/____
Yes No Congenital Heart Lesions	**Yes No** Hepatitis____/____	**Yes No** Ulcers
Yes No Dementia/Alzheimer's Disease	**Yes No** High Blood Pressure	**Yes No** Venereal Disease
Yes No Developmental Disabilities		**Yes No** Other____________________

Do You Use Tobacco? ☐ Yes ☐ No

☐ Cigarettes – Packs/Day:__________ ☐ Chew - #/Day:__________ ☐ Pipe - #/Day:__________ ☐ Cigars - #/Day:__________

PATIENT DENTAL HISTORY

1. How long has it been since your last dental visit?____
2. Are you having any specific problems with your teeth, gums or mouth at this time? **YES NO**
   If Yes please list____
3. Do you clench or grind your teeth? If Yes, When? Day or Night **YES NO**
4. Do you notice any popping, clicking or soreness in the jaw? **YES NO**
5. Have you undergone any previous periodontal surgery or oral surgery? **YES NO**
   If Yes, please list____
6. Have you had any head, neck or jaw injuries? **YES NO**
7. Have you had any serious trouble associated with any previous dental treatment? **YES NO**
   If Yes, please list____
8. Have you ever experienced any ill effects from dental anesthetics, antibiotics or any other drug? **YES NO**
   If Yes, please list____

Signature:________________________________Relationship to Patient:______________________Date:__________

Doctor's Signature:______________________________________Date:__________B/P:__________Pulse:__________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Creekside Dental ~ Yakima, WA

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 of my dental provider's *Notice of Privacy Practices* containing 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*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

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:

____

Additional Disclosure Authority: (concluded **with discussion RE: patient etc.)**

OTHER-SPECIFY Names Signatures ID

____

____

____

____

____

- -

For Office Use Only:

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

The patient refused to sign

Communication barriers

Emergency situation

Other

Creekside Dental ~ Yakima, WA

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment. We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you.

Payment. We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your health plan containing certain health information.

Healthcare Operations. We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care. We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a

person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief. We may use or disclose your health information to assist in disaster relief efforts.

Required by Law. We may use or disclose your health information when we are required to do so by law.

Public Health Activities. We may disclose your health information for public health activities, including disclosures to:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security. We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS. We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Law Enforcement. We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.

Health Oversight Activities. We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please Contact:

Creekside Dental
1501 South 40th Avenue
Yakima, WA 98908-3963
509-577-8277

If we cannot resolve your complaint you have the right to file a complaint with the Secretary of the department of Health & Human Services (HHS) Office for Civil Rights, 2201 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will You be penalized for filing a complaint.

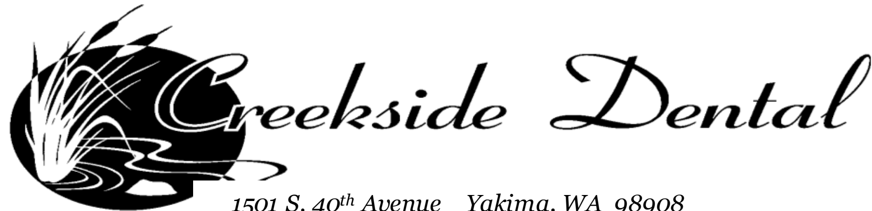
Creekside Dental Informed Consent Acknowledgement

I have read and understand the information on the consent form.

I understand the risks and complications listed are not all inclusive, and l have had all my questions answered to my full understanding and satisfaction.

Treatment	Tooth/Teeth
☐ X-rays	
☐ Cleaning/Periodontal Treatment	
☐ Anesthetic	
☐ Fillings	
☐ Root Canal Treatment and Puplotomy	
☐ Crown and Bridge	
☐ Extraction	
☐ Implant	
☐ Orthodontic	
☐ Orthodontic	

Signature____ Date: ______________



1501 S. 40th Avenue Yakima, WA 98908
(509) 577-8277 Fax (509) 573-4858
www.creeksidedental.net

Notice of No-Show Policy

Effective 9/17/2024

This notice is to inform you of our new office policy regarding no-shows or cancelling appointments with less than 24 hours notice.

We strongly value our patient's time. When your appointment is made, a room is reserved our staff is ready and waiting, your records are prepared, and special instruments are readied for your individual visit. We require our patients give us a minimum of 24 hours notice when cancelling or rescheduling an appointment. This courtesy would allow us to make it possible to give your reserved room to another patient needing work.

1st No-Show or last minute Cancellation: You will receive a verbal communication reiterating our policy.

2nd No-Show or last minute Cancellation: You will be charged a **$50.00 No-Show Fee** and informed verbally that we will no longer be able to schedule treatment appointments for you. All upcoming appointments will be cancelled. You will be informed of our walk-in times and dates and be seen only on a walk-in basis.

Multi-Family Appointments: If two or more family members scheduled on the same day No-Show or last minute cancel appointment, only one family member at a time will be scheduled for all future appointments.

Patients that are more than 10 minutes late to their scheduled appointment will possibly be rescheduled.

We know that sometimes things don't go as planned and changes on scheduled appointments need to be made. Which is why we give patients a 1 week and 48 hour courtesy reminder of the upcoming appointment. Thanks to this, you have plenty of time to contact us to make any changes necessary.

We will be implementing the **$50.00 No-Show Charge Immediately** and must be paid if full before any appointments are reappointed.

Name____DOB_________________________________

Sign____Date_________________________________