Bill Gilbert DDS
comfort dentistry for all generations

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

Social Security #: _____ **(Required to process your claim and establish your account)**

Address: _____

Home #: _____ **Cell#:** _____ **E-mail:** _____

Name of responsible party _____ **Relationship:**_____

Address: _____

Phone #: _____ **DOB:** _____ **Social Security#** _____

Primary Insurance Information (If any)
Insurance Provider: _____ **Phone#:** _____

Group Plan/Employer Name: _____ **Member ID#:**_____

Claim Address;_____

Subscriber's Name: _____ **DOB:** _____

Social Security #: _____ **(Required if this person is insurance primary subscriber)**

Secondary Insurance Information (If any)

Insurance Provider: _____ **Phone#:** _____

Group Plan/Employer Name: _____ **Member ID#:**_____

Claim Address;_____

Subscriber's Name: _____ **DOB:** _____

Social Security #: _____ **(Required if this person is insurance primary subscriber)**

Emergency Contact Person: _____ **Phone#:** _____
Address: _____
Relationship to patient: _____

Whom may we thank for referring you to our office? _____

I understand and agree that regardless of insurance status I am ultimately responsible for any service rendered including late cancellation charge and missed appointment charge. I certify this information is true and correct. I understand and agree with the office financial policy.

_____ _____
Signature of responsible party **Date**

Relationship to patient: _____

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FINANCIAL POLICY

Insurance is a contract between you or your employer and your insurance provider. It is designed to pay a portion of the costs associated with your dental care.

Please keep in mind Dr. Gilbert performs services without assumption your insurance company will pay the completed treatment. We treat patients based on their needs not what insurance will or will not pay.

As a courtesy we send claims to your insurance, however; **you are ultimately responsible for any accrued treatment fees as well as the remaining balance after your insurance provider has paid.**

*Please take note that you are responsible to pay the full amount due if your insurance provider has not paid your claim within 90 days from the date of service.

*It is your responsibility to know your insurance benefits and notify us of any changes in your coverage.

*Insured patients are also responsible to pay estimated co-pay at the time of service.

*Non-insured patients must pay accrued charges at the time of service.

We accept major credit cards such as Visa, Mastercard, and Discover. We also accept cash and checks.

We appreciate your cooperation. Thank you.

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MEDICAL HISTORY

To assist us in serving you, please complete the following form. This information is important to your dental health.
Please inform us if there have been any changes in your health. If you have any questions, do not hesitate to ask.

Patient Name_____ Date of Birth _____ Age_____

Name of your physician_____ Date of last visit to physician _____

Do you have or have you had any of the following? Please check that apply:

Allergy **Problems**
- o Hay fever
- o Sinus Problems
- o Shortness of breath
- o Skin rashes
- o Asthma
- o Taking allergy medication

Intestinal Problems
- o Ulcers
- o Crohn's disease
- o Irritable Bowel Syndrome
- o Acid Reflux

Bone or Joint Problems
- o Arthritis
- o Back or Neck pain
- o Joint Replacement (e.g. total hip)

Blood Problems
- o Easy bruising
- o Frequent nose bleeds
- o Abnormal Bleeding
- o Blood Disease (Anemia)

Heart Problems
- o Chest Pain
- o Shortness of breath
- o Blood pressure problem
- o Heart Murmur
- o Heart Valve Problem
- o Pacemaker
- o Artificial Heart Valve
- o Rheumatic fever

Diabetes
Urniate more than 6x/day
- o Thirsty or dry mouth
- o Family history of diabetes

Others:
- o Fainting spells
- o Seizures/Epilepsy
- o Cancer/Tumor
- o Hepatitis
- o Jaundice
- o Liver Trouble
- o Herpes
- o HIV positive/AIDS
- o Glaucoma

During the past 12 months have you taken any of the following?
- o Antibiotics
- o Sulfa drugs
- o Anticoagulants (e.g.Coumadin)
- o High blood pressure medication
- o Tranquilizers
- o Insulin, Orinase, or similar drug
- o Aspirin
- o Digitalls or drugs for heart trouble
- o Nitroglycerin
- o Cortisone (steroids)
- o Fen-Phen
- o Other _____

Are you allergic or have you reacted
Are you allergic or had reacted to the following?
- o Local Anesthetics (Novocain)
- o Penicillin
- o Other antibiotics: _____
- o Aspirin
- o Ibuprofen
- o Codeine
- o Sulfa Drugs
- o Sleeping pills
- o Anxiety pills
- o Other: _____

Do you wear contact lenses? Y N

Do you drink alcoholic beverage? Y N
If so, how often? _____

Do you smoke tobacco products? Y N
If so, how much a day? _____

Do you chew tobacco? Y N
If so, how often a day? _____

Do you have sleep apnea? Y N

For Women
- o Are you taking contraceptives? Y N
- o Are you taking hormones? Y N
- o Are you pregnant? Y N

If so, expected delivery date _____
- o Have you reached menopause? Y N

If so, do you have any symptoms? Y N

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DENTAL HEALTH HISTORY

Please mark any questions that you would answer "YES":

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 difficulty in chewing your food? _____ ○
Do you chew on only one side of your mouth? _____ ○
Do you avoid brushing any part of your mouth because of pain? _____ ○
Do you gums bleed easily?_____ ○
Do your ums bleed when you floss?_____ ○
Do your gums feel swollen or tender? _____ ○
Have you ever noticed slow hearing sores in or about your mouth? _____ ○
Are your teeth sensitive? _____ ○
Do you feel twinges of pain when your teeth come in contact with foods or liquid:
Hot_____ Cold_____ Sour_____ Sweet_____
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? _____ ○
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 jaw frequently? _____ ○
Does your jaw 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 awaking in the morning? _____ ○
Does jaw pain/discomfort affect your appetite, sleep, daily routine, or other activities? __ ○
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 disorder (TMD, TMJ)? _____ ○
Do you have pain in the face, cheeks, jaw, 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? _____ ○
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____ ○
If so, please describe: _____
_____

Date _____ **Signature of Patient**_____

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ACKNOWLEDGEMENT OF PRIVACY RIGHTS

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:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed of Dr. William D. Gilbert's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices.* I understand that Dr. William D. Gilbert has the right to change the *Notice of Privacy Practices* from time to time and that I may contact this office at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

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. I also understand that you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

I authorized (Name):_____
to obtain my health and account information.

Relationship to patient:_____

Patient's Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES

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

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law 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 health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. 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.

You have certain rights in regards to your protected health information, which you can exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family member, 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 remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect and copy your protected health information.
- The right to request an amendment to your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of April 14, 2003 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, contact:

Privacy Officer
Dr. William D. Gilbert
14655 Bel-Red Road
Bellevue, WA 98007
(425) 957-4700

For more information about HIPAA or to file a complaint:

U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
877-696-6775 (toll-free)

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PATIENT RECORDS REQUEST FORM

Name of patient whose record is requested: _____

DOB: _____ Phone: _____

Address: _____

Please provide a copy of the record as indicated below:

○ The full health record maintained by this provider/practice

○ The health record for the following time frame:

_____ through _____

○ A specific section of the health record as described below:

_____

_____

○ I understand, as permitted by federal and state law, that a fee may be charged for copying records and/or x-rays.

Please e-mail requested records to: **toothdoc@dr-gilbert.com**

Signature of Patient
_____

Signature of Authorized Personal Representative _____

Relationship to Patient _____

Date _____