Riverview Family Dental

YOUR FIRST VISIT CHECKLIST

Welcome to our practice. We want to make sure your first visit to our office is a great one. To help us accomplish this, please use the list below to ensure we have all the information we will need and that you are prepared for your first visit.

- Complete new patient forms and bring them with you to your appointment.
- Arrive 10 minutes before your appointment for paperwork.
- Bring your insurance card if one was issued.
- Bring your driver's license or other government issued photo ID.
- If you are a dependent on an insurance plan please have:
  - Insured's Name, Address, and Phone Number
  - Insured's Date of Birth
  - Insured's Employer
  - Insured's Plan, Member ID#, or Social Security Number
  - Insurance Group Number
  - Insurance Company Name and Phone Number
- Have a list of all the medications you are taking.
- Take any pre-medications required by your medical doctor.

We look forward to meeting you.

Andrew P. Johnson, DMD and team.

101 11th St. NE ●East Wenatchee, WA 98802●(509)884-7137

Riverview Family Dental - Andrew P. Johnson, DMD

PATIENT INFORMATION

ABOUT YOU

Name:_____ Preferred Name:_____ ☐ Male ☐ Female

Address:_____ City_____ State:____ Zip:_____

Birth Date:___/___/___ SSN:_____ Marital Status: ☐ Single ☐ Married ☐ Child ☐Other

Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone:(____)_____

May we contact you via text messaging to your cell phone number? _____

May we contact you by email?_____ Email Address:_____

Employer:_____ Occupation:_____ How long there_____

How did you hear about our office?_____

PERSON RESPONSIBLE FOR ACCOUNT

☐ Same as above (skip to next section if you marked this box)

Name:_____ Birth Date:___/___/___ SSN:_____ Relation to Patient:_____

Billing Address:_____ City:_____ State____ Zip:_____

Home Phone:(____)_____ Work Phone:(____)_____ Cell Phone:(____)_____

Employer:_____ Occupation:_____ How long there_____

SPOUSE INFORMATION & EMERGENCY CONTACT

Spouse Name:_____ Birth Date:___/___/___

Employer:_____ Work Phone:(____)_____

Emergency Contact Person:_____ Phone:(____)_____ Relation to Patient_____

DENTAL INSURANCE

Primary Insurance

Subscriber Name:_____ Relation to Patient_____ Subscriber Birth Date:___/___/___

Subscriber SSN/ID:_____ Subscriber Employer:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone: (____)_____ Group/Policy Number:_____

Secondary Insurance

Subscriber Name:_____ Relation to Patient_____ Subscriber Birth Date:___/___/___

Subscriber SSN/ID:_____ Subscriber Employer:_____

Insurance Company Name:_____

Insurance Company Address:_____

Insurance Company Phone: (____)_____ Group/Policy Number:_____

FINANCIAL POLICY

We will provide you with an estimate of fees for your planned dental treatment. If you have dental insurance, the estimate will include the portion we expect the dental insurance to pay. We estimate your portion based on the insurance information we have. It is only an estimate. It is not a guarantee of coverage.

Unless another financial arrangement has been made, we require full payment of your portion at the time of service.

As a courtesy, we will bill your dental insurance for the portion we expect them to pay. You will be responsible for the balance on fees for dental services not completely covered by your dental insurance.

If your dental insurance does not pay within 90 days, we reserve the right to request payment in full for services from you, and let you collect the insurance funds that are due to you. This is rare, but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Our office is not, and cannot be a part of that legal contract. Ultimately, you are responsible for all charges incurred in our office.

Payment Options: We accept cash, check, debit card, Visa, MasterCard, Amex, and Discover. On approved credit, financing/payment plan options are available, some of which are interest-free.

Returned checks are subject to a $25 accounting fee. Initial_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Andrew P. Johnson, DMD all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party(Please Print)_____

Responsible Party Signature:_____

Relationship to Patient:_____ Date:_____

CONSENT

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature:_____

Riverview Family Dental Medical History

Your Name:_____

Do you have a personal physician? ☐ Yes ☐ No

Physician's Name: _____

Physician's Phone: _____

Date of last visit: _____

Are you currently under the care of a physician? ☐ Yes ☐ No

Please explain:_____

Do you use tobacco in any form? ☐ Yes ☐ No

Have you ever had any surgeries or been hospitalized? ☐ Yes ☐ No

If yes, what for?_____

Are you taking any medications? ☐ Yes ☐ No

Please list each one: _____

_____

Have you experienced or been told you have any of the following conditions:

Yes	No	Conditions
☐	☐	Abnormal Bleeding/Bruise Easily
☐	☐	Alcohol Abuse
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Angina Pectoris
☐	☐	Arthritis
☐	☐	Artificial Heart Valve
☐	☐	Asthma
☐	☐	Blood Transfusion
☐	☐	Cancer
☐	☐	Chemotherapy
☐	☐	Cold Sores
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Difficulty Breathing
☐	☐	Drug Abuse
☐	☐	Emphysema
☐	☐	Epilepsy
☐	☐	Facial Surgery
☐	☐	Fainting Spells
☐	☐	Frequent Headaches
☐	☐	Glaucoma

Yes	No	Conditions
☐	☐	HIV or AIDS
☐	☐	Heart Attack
☐	☐	Heart Disease
☐	☐	Heart Murmur
☐	☐	Heart Surgery
☐	☐	Hepatitis A
☐	☐	Hepatitis B
☐	☐	Hepatitis C
☐	☐	High Blood Pressure
☐	☐	Joint Replacement
☐	☐	Kidney Problems
☐	☐	Liver Disease
☐	☐	Low Blood Pressure
☐	☐	Pace Maker
☐	☐	Psychiatric Problems
☐	☐	Radiation Therapy
☐	☐	Rheumatic Fever
☐	☐	Seizures
☐	☐	Sexually Transmitted Disease
☐	☐	Shingles
☐	☐	Sickle Cell Disease
☐	☐	Sinus Problems
☐	☐	Stroke

Yes	No	Conditions
☐	☐	Thyroid Problems
☐	☐	Tuberculosis
☐	☐	Ulcers

Yes	No	Allergies
☐	☐	Aspirin
☐	☐	Codeine
☐	☐	Dental Anesthetic
☐	☐	Erythromycin
☐	☐	Jewelry/Metals
☐	☐	Latex
☐	☐	Nitrous Oxide
☐	☐	Penicillin
☐	☐	Other _____

Yes	No	If Female, Please Answer
☐	☐	Are you taking birth control pills ?
☐	☐	Are you pregnant? If so, # of Weeks_____
☐	☐	Are you nursing?

Have you experienced or have you been told you have a condition, illness or injury not listed above? ☐ Yes ☐ No

Please explain:_____

I understand that the information that I have given today 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 of Patient/Responsible Party: _____ Date: _____

Updated (Date/Initial)

_____/_____ _____/_____ _____/_____ _____/_____ _____/_____ _____/_____

Riverview Family Dental

Dental History

Your Name:_____

How may we help you today?_____

Your current dental health is ☐ Good ☐ Fair ☐ Poor

Are you currently in pain? ☐ Yes ☐ No

Do your gums bleed? ☐ Yes ☐ No

Have you ever been told you have Periodontal/Gum Disease? ☐ Yes ☐ No

Do you now have or have you had pain/discomfort in your jaw joint (TMJ)? ☐ Yes ☐ No

Do you like your smile? ☐ Yes ☐ No

Are you happy with the color of your teeth? ☐ Yes ☐ No

Is there anything you would like to change about your smile? ☐ Yes ☐ No

If yes, what? _____

Are your teeth sensitive to heat, cold, chewing or anything else? ☐ Yes ☐ No

Have you ever had any unfavorable dental experience? ☐ Yes ☐ No

When was your last dental cleaning? _____

When was your last dental visit?_____

Why did you leave your previous dentist? _____

How can we accommodate you better during your dental visit?_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence.

Signature of Patient/Responsible Party: _____ Date: _____

RIVERVIEW FAMILY DENTAL

101 11th St. NE • East Wenatchee

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 dental 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.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters.)

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 AND 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.

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.

Our Privacy Official: Dr. Andrew Johnson
Contact information: 101 Eleventh St. NE
East Wenatchee, WA 98802
(509)884-7137
apjdental@gmail.com

NOTICE OF PRIVACY PRACTICES

Acknowledgement of Receipt

You may refuse to sign this acknowledgement.

I, _____, acknowledge receipt of the
(patient or guardian)
NOTICE OF PRIVACY PRACTICES from Andrew P. Johnson, DMD, Inc.

_____
Signature

_____
Date

FOR OFFICE USE ONLY

We tried to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

____ Patient refused to sign.

____ Emergency situation prevented obtaining the acknowledgement

____ Communication barriers

____ Other (specify below)

_____

_____

_____