

**PATIENT REGISTRATION**

ID: \_\_\_\_\_ Chart ID: \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Patient Is:  Policy Holder Preferred Name: \_\_\_\_\_  
 Responsible Party

Responsible Party (if someone other than the patient) \_\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Birth Date: \_\_\_\_\_ Soc Sec: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

Responsible Party is also a Policy Holder for Patient  Primary Insurance Policy Holder  Secondary Insurance Policy Holder

Patient Information \_\_\_\_\_

Address: \_\_\_\_\_ Address 2: \_\_\_\_\_

City: \_\_\_\_\_ State / Zip: \_\_\_\_\_ Pager: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Ext: \_\_\_\_\_ Cellular: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Married  Single  Divorced  Separated  Widowed

Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Soc. Sec.: \_\_\_\_\_ Drivers Lic: \_\_\_\_\_

E-mail: \_\_\_\_\_  I would like to receive correspondences via e-mail.

**Section 2**

Employment Status:  Full Time  Part Time  Retired

Student Status:  Full Time  Part Time

Medicaid ID: \_\_\_\_\_ Pref. Dentist: \_\_\_\_\_

Employer ID: \_\_\_\_\_ Pref. Pharmacy: \_\_\_\_\_

Carrier ID: \_\_\_\_\_ Pref. Hyg.: \_\_\_\_\_

**Section 3**

Credit Card: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Referred By: \_\_\_\_\_

**Primary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec.: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

**Secondary Insurance Information**

Name of Insured: \_\_\_\_\_ Relationship to Insured:  Self  Spouse  Child  Other

Insured Soc. Sec.: \_\_\_\_\_ Insured Birth Date: \_\_\_\_\_

Employer: \_\_\_\_\_ Ins. Company: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Address 2: \_\_\_\_\_ Address 2: \_\_\_\_\_

City,State,Zip: \_\_\_\_\_ City,State,Zip: \_\_\_\_\_

Rem. Benefits: \_\_\_\_\_ .00 Rem. Deduct: \_\_\_\_\_ .00

# MEDICAL HISTORY

PATIENT NAME \_\_\_\_\_ Birth Date \_\_\_\_\_

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 \_\_\_\_\_
- Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?  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?  Nursing?  
 Taking oral contraceptives?

Are you allergic to any of the following?

- Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  Sulfa Drugs
- Other If yes, please explain: \_\_\_\_\_

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

- |   |  |  |  |   |
|---|--|--|--|---|
| <input type="checkbox"/> AIDS/HIV Positive      | <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Frequent Headaches    | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Alzheimer's Disease    | <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Genital Herpes        | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anaphylaxis            | <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Anemia                 | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Angina                 | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Attack/Failure  | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Arthritis/Gout         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Heart Pacemaker       | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Artificial Joint       | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Osteoporosis          | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Disease          | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Blood Transfusion      | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Breathing Problem      | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bruise Easily          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                 | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> High Cholesterol      | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chemotherapy           | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Renal Dialysis        | <input type="checkbox"/> Ulcers                     |
|   |  |  |  | <input type="checkbox"/> Venereal Disease           |
|   |  |  |  | <input type="checkbox"/> Yellow Jaundice            |

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 \_\_\_\_\_

**KENMORE DENTISTRY**  
**DR. ANTHONY A SANTORSOLA, DDS, PS**  
**DR. LEO HENRICHSEN, DDS**  
**5723 NE Bothell Way, Suite A**  
**Kenmore, Washington 98028**  
**(206) 525-2813**

## **Financial Arrangements**

Financial arrangements will be made at the time treatment is scheduled. We regret we are no longer able to personally carry loans to patients over extended periods of time and still be able to provide high quality dentistry at reasonable fees, but several payment options are available.

## **Financial Options**

- For patients with dental insurance, the uninsured portion is due at the time of treatment. We will be happy to bill your insurance for you and bill your credit card (Visa/MC/Amex/Disc) for the uninsured portion of your bill.
- For uninsured patients, all fees are due at the time of treatment. You may use cash, check, or credit card (Visa/MSC/Amex/Disc).
- For fees exceeding \$500, you may pay ½ at the time of treatment and the other ½ in 3 monthly payments.
- For those who need extended payment arrangements, we offer CareCredit, a finance plan that offers interest-free loans for up to 12 months and low interest loans up to 60 months on approval of credit.
- There is a 5% discount taken for all payments made in full at the time of treatment for uninsured patients.
- There is a 5% discount for uninsured persons over 60yrs.

Regardless of any insurance that I may have, I understand that I am fully responsible for the full amount of fees and the financial arrangements agreed to in this matter.

*Patient's Signature:* \_\_\_\_\_ *Date:* \_\_\_\_\_

Kenmore Dentistry  
 5723 NE Bothell Way, Suite A  
 Kenmore, WA 98028  
 206-525-2813

**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 Kenmore Dentistry. 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.

Kenmore Dentistry reserves the right to change the privacy practices that are 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 to me.

<b>ADDITIONAL DISCLOSURE AUTHORITY</b>			
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.			
Any Member of my Immediate Family		YES	NO
Spouse Only		YES	NO
Other (Please Specify):		YES	NO

\_\_\_\_\_  
 Name of Patient or Personal Representative

\_\_\_\_\_  
 Signature of Patient or Personal Representative

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Description of Personal Representative's Authority

=====

**OFFICE USE ONLY BELOW THIS LINE**  
**Record of Acknowledgement not obtained**

Provided Prior to Treatment		YES		NO
Date Provided:				
Reason for Denial		Needed More Time to Review Statement of Privacy Practices		
		Wanted to Consult With Another Person, Before Signing		
		Unable to Sign		
		Reason Not Given		
		Other (Explain)		

# Statement of Privacy Practices

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect 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 to anyone – even family members – without your written consent. 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 of 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 Health Information (PHI)

We will only request personal information needed to provide our standard 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 Health 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 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.

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 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