Patient Registration

W Dentistry

(Office Use only) Chart ID: _____

Patient Information

Preferred Name:

Full First Name: Last Name: MI:

Address:

City, State, Zip:

Home Phone:	Cell Phone:
Work Phone: Ext #:	Email:
Birthdate: Age:	☐ Patient is the Primary Insurance Policy Holder
Social Security:	☐ Patient is also the Responsible Party
Driver's License:	☐ If not the Responsible Party, please fill out section below.

I prefer to receive communication via (circle all that apply): phone call email text

Marital Status (circle): married single divorced separated widowed

Employer:	Employment Status (circle): full time part time retired
Student Status (circle): full time part time n/a	Preferred Pharmacy:

Responsible Party

* If someone other than the patient.

First Name: Last Name: MI:

Address, City, State, Zip:

Home Phone:	Cell Phone:
Work Phone: Ext #:	Email:
Sex (circle): M F	Relationship to Patient:
Birthdate:	☐ Responsible Party is also a Policy Holder to Patient
Social Security:	☐ Responsible Party is Primary Insurance Policy Holder

Primary Insurance Information

Name of insured: _____ Relationship to insured: _____

Employer: _____ Insurance Company: _____

Employer Address: _____ Group ID: _____

City, State, Zip: _____ Member ID: _____

Dental History

W Dentistry

Patient Name: _____ Today's Date: _____

What is the main reason for your visit today? _____

Date of Last Dental Visit: _____ Last Dental Cleaning: _____ Last Full Mouth X-Rays: _____

What was done at your last dental visit? _____

Previous Dentist's Name: _____

Previous Dentist's Phone: _____ Previous Dentist's City, State: _____

Reason for Leaving: _____

How often do you have dental examinations? _____ Brush?_____times/day Floss? _____

Have you ever used, or currently use, topical fluoride? _____

What other dental aids do you use? (i.e waterpik, airfloss, toothpick etc.) _____

Do you have any dental problems or pain now? YES NO

If yes, please describe: _____

Are any of your teeth sensitive to hot or cold?	Yes	No
Are any of your teeth sensitive to sweets?	Yes	No
Are any teeth sensitive to biting or chewing?	Yes	No
Have you noticed any mouth odors or bad taste?	Yes	No
Do you get cold sores, blisters, or other oral lesions?	Yes	No
Do your gums bleed or hurt?	Yes	No
Have your parents had gum disease or tooth loss?	Yes	No
Have you noticed any loose teeth?	Yes	No
Does food often get caught in between your teeth?	Yes	No
If yes, where: _____		
Do you:		
Clench or grind your teeth while awake or asleep?	Yes	No
Bite your lip or cheek regularly?	Yes	No
Hold foreign objects with your teeth (pen,nails,etc)?	Yes	No
Mouth breathe while awake or asleep?	Yes	No
Have tired jaw muscles, especially when you wake?	Yes	No
Snore or have any other sleeping disorders?	Yes	No
Smoke/chew tobacco or use any tobacco products?	Yes	No

Have you ever had:		
Braces or orthodontic treatment?	Yes	No
Extractions or oral surgery?	Yes	No
Gum surgery or periodontal treatment?	Yes	No
Your bite adjusted or teeth grinded?	Yes	No
A nightguard or other mouthguard?	Yes	No
A serious injury to the mouth or head?	Yes	No
Clicking or popping of the jaw?	Yes	No
Pain (joint, ear, side of face)?	Yes	No
Difficulty in opening or closing, or locked jaw?	Yes	No
Difficulty chewing on either side of the mouth?	Yes	No
Constant headaches?	Yes	No
Sore muscles (neck, shoulders)?	Yes	No
Are you satisfied with your teeth's appearance?	Yes	No
Would you like to improve the look of your smile?	Yes	No
Have you ever had an upsetting dental experience?	Yes	No
If yes, please describe: _____		
_____		

Do you feel nervous about having dental treatment? Yes No

If yes, please describe: _____

Have you ever taken or currently take a pre-medication prior to dental treatment? Yes No

If yes, please describe: _____

Is there anything else you would like us to know for your dental visit? Yes No

If yes, please explain: _____

_____

Patient or Guardian Signature: _____

Medical History

W Dentistry

Patient Name: _____ Birth Date: _____

Dental personnel primarily treat the area in and around your mouth. However, any health problems you may have or medications that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions accurately.

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
Do you take, or have you taken, Phen-Fen or Redux? ☐Yes ☐No If Yes, please explain: _____
Have you ever taken Foxamax, Boniva, Actonel or any other medications containing bisphosphonates? ☐Yes ☐No If Yes, please explain: _____
Are you on a special diet? ☐Yes ☐No If Yes, please explain: _____
Do you smoke cigarettes or use tobacco? ☐Yes ☐No If Yes, please explain: _____
Do you use controlled substances? ☐Yes ☐No If Yes, please explain: _____

Women: Are you pregnant or trying to get pregnant? ☐Yes ☐No Taking oral contraceptives? ☐Yes ☐No Nursing? ☐Yes ☐No

Are you **allergic** to any of the following (please circle all that apply):
Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa Drugs Other: _____

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

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

Have you ever had any serious illness not listed above: ☐Yes ☐No If yes, please name:_____

Please list medications you are taking: _____

The questions on this form have been accurately answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (the patient's) health. It is my responsibility to inform W Dentistry of any changes in medical status.

Signature of Patient, Parent, or Guardian: _____ Date:_____

NOTICE OF PRIVACY PRACTICES

W Dentistry

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

You will be asked to acknowledge and sign that you have received our notice of privacy practices.

W Dentistry respects your privacy. We understand that information about you and your health is very personal and therefore we will strive to protect your privacy as required by law. Individually identifiable information about your past, present, or future health or condition, the provision of dental health care to you, or payment for such dental health care is considered "Protected (Personal) Health Information" or "PHI". We will only use and disclose your personal health information as allowed by applicable law.

We are committed to excellence in the provision of state-of-the-art health care services through the practice of patient care and education. Therefore, as described below, we train our staff to be sensitive about privacy and to respect the confidentiality of your personal health information.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your PHI. We are required to abide by the terms of this Notice of Privacy Practices so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice of Privacy Practices effective for all personal health information maintained by us.

Except as outlined below, we will not use your PHI for any purpose unless you have signed a form authorizing the use of disclosure. This form will describe what information will be disclosed, to whom, for what purpose, and when. You have the right to revoke that authorization in writing, except to the extent we have already relied upon it.

1. Permitted Uses and Disclosures of Your Protected Health Information
   The following categories detail the various ways in which we may use or disclose your PHI. For each category of uses or disclosures we will give you illustrative examples. It should be noted that while not every use or disclosure will be listed, each of the ways we are permitted to use or disclose information will fall into one of the following categories.

   A. **For Treatment**: We may disclose PHI to our dental staff for treatment purposes. We can also receive or share information with others who may provide you with care.
   B. **For Payment**: We disclose PHI in order to fulfill our duty to provide your coverage, process your insurance claims, determine your benefits and make payment for services provided to you.
   C. **For Health Care Operations**: We disclose your PHI as a part of certain operations such as quality assessment and to improve services. We may use or disclose your PHI without your authorization for other reasons, such as public health purposes, auditing purposes, fraud and abuse detection, research studies, your dental health plan, accounting, and emergencies. We provide PHI when required by law, such as law enforcement in specific circumstances, as for judicial, legal, risk management or administrative proceedings. In any other situation, we will ask for you written authorization before using or disclosing your PHI. If you choose to sign an authorization to allow disclosure of your PHI, you can later revoke that authorization to stop any future uses and disclosures (other than for the Permitted Uses and Disclosures of your PHI as described, and what may fall under those categories).

D. **Appointment Reminders**: We may use and disclose your information to contact you as a reminder or confirmation that you have an appointment with us for treatment or dental care. The reminder may be by mail, email, text message, or telephone message.
E. **Treatment Alternatives**: We may use and disclose dental information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.
F. **Health Related Benefits and Services**: We may use and disclose information to tell you about health-related benefits or services that may be of interest to you.
G. **Individuals Involved in Your Care or Payment for Your Care**: We will only disclose PHI to a patient's parent or guardian, representative with power of attorney, and to people that the patient invites to physically accompany him or her. In certain emergency situations it may not be possible to have the patient present, in which case we may, in the exercise of professional judgment, determine whether the disclosure is in the best interests of the patient, and if so, disclose only the information directly relevant to the person's involvement with the patient's health care, or related payment.
H. **Business Associates**: Certain aspects and components of our services are performed through contract with outside persons or organizations, such as auditing and legal services. At times it may be necessary for us to provide your PHI to one or more of these outside persons or organizations who assist us with our payment/billing activities and healthcare operations. In such cases, we require these business associates to appropriately safeguard the privacy of your information.

2. Individual Rights

In most cases, you have the right to view or get a copy of your PHI. You also have the right to receive a list of instances where we have disclosed your PHI without your written authorization for reasons other than treatment, payment or health care operations. If you believe that information in your record is incorrect or if important information is missing, you have the right to request that we correct the existing information or add the missing information.

You may request in writing that we not use or disclose your PHI for treatment, payment and healthcare operations except when specifically authorized by you, when required by law, or in emergency circumstances. Although we are unable to take back any disclosures we have already made with your permission or pursuant to this notice, we will consider your request but we are not legally required to accept it. You also have the right to receive confidential communications of PHI by alternative means, if you clearly state that disclosure of all or part of your PHI could endanger you.

3. Complaints

If you are concerned that we have violated your privacy rights, or disagree with a decision we have made about access to your records, you may contact us at our practice address. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized for making a complaint.

4. Our Legal Duty

We are required by law to protect the privacy of your information, provide this notice about our information practices, and follow the information practices that are described in this notice.

We may change our policies at any time. We reserve the right to make the revised or changed notice effective for dental information we already have about you as well as any information we receive in the future. You can also request a paper copy of our notice at anytime by contacting our dental practice.

W Dentistry
Kari C. Woo DDS PLLC
22619 SE 64th PL Suite 110
Issaquah, WA 98027
P 425.392.7000

My signature below confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act (HIPAA). I have been informed of my dental provider's "Notice of Privacy Practices" which contains a description of the uses and disclosures of my protected health information. I have been given the right to review and/or receive a copy of such "Notice of Privacy Practices", which W Dentistry has a copy accessible to any patient. 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 practice address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed for treatment, payment, or health care operations. I understand that you (dental provider) are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: ____ Date: __________________________

Print Patient Name: ____

Relationship to Patient (if other than self): ____

- -

For office use only:

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

____ The patient refused to sign

____ Communication barriers

____ Emergency situation

____ Other: ____

DENTISTRY

Kari C. Woo DDS

FINANCIAL POLICY

DOWN PAYMENT TO RESERVE YOUR DENTAL APPOINTMENT

Our policy requires 50% down payment to schedule your appointment for that treatment. This is to reserve that time and materials for you. The remaining balance is due when you arrive on the day of treatment.

PREPAYMENT DISCOUNT

We offer a 5% discount off the total fee when you pay for the entire treatment plan in one full payment. This must be paid in one lump payment prior to scheduling the treatment appointments.

DENTAL INSURANCE

If you have dental insurance, we will file the appropriate claim forms to your dental insurance company as a courtesy for you. If your insurance denies coverage, the amount will become your responsibility and must be paid by you even if it is after your original estimated patient portions were already paid. We will make every possible effort to help you obtain your maximum dental benefits, but we CANNOT GUARANTEE that your insurance company will pay.

> The amount of your patient portion is always only an **ESTIMATE.** Insurance companies often cannot or will not provide us with exact coverage amounts. You will be billed and responsible for any amount that differs from the original patient estimate.

MISSED APPOINTMENTS

There is a **$75.00 fee when we are notified less than 48 hours prior** to your scheduled appointment time of the need to cancel or reschedule. These missed appointments present a challenge for the entire office schedule so communicating with us as soon as possible is much appreciated.

RESPONSIBILITY AS OUR PATIENT

I acknowledge my responsibility for payment of any services rendered by W Dentistry in accordance with the terms of this financial policy. I understand that I have the final responsibility for payment of all fees for any treatment or services, and that it is my responsibility whether or not insurance (or any third party) pays for all, part, or none of the charges.

By signing below, I fully understand and accept the terms of this financial policy and will abide to them:

_____ _____

Print Patient Full Name | Signature of Patient (or Parent/Guardian)

_____ _____

Print Parent/Guardian Full Name (if applicable) | Date

DENTISTRY

CONSENT FOR MEDIA RELEASE

I grant permission to Kari C. Woo DDS PLLC ("W Dentistry"), its representatives and employees, to use photographs, videos, and other related information of me and/or my dependents for the purpose(s) of social media, website content, marketing, education, or other public relations. I authorize W Dentistry to share such information and media in print or electronic with or without names.

I have read and understand the above. Please mark YES or NO below.

_____**YES**, I give consent to release such media for the purposes indicated:

Print Patient Name: _____

Signature: _____
*If patient is a minor, parent or guardian must sign.

Date: _____

_____**NO**, I do not consent to release as described above:

Print Patient Name: _____

Date: _____