PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SSN
PATIENT'S HOME ADDRESS: STREET	CITY	STATE	ZIP		HOME PHONE
MARITAL STATUS S ☐ M ☐ D ☐ W ☐	PATIENT'S EMPLOYER				OCCUPATION
WORK ADDRESS STREET	CITY	STATE	ZIP		WORK PHONE
PERSON FINANCIALLY RESPONSIBLE FOR THIS PATIENT ACCOUNT *(IF DIFFERENT FROM ABOVE)* NAME			RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ OTHER _____		
MAILING ADDRESS: STREET	CITY	STATE	ZIP		HOME PHONE
SPOUSE NAME	SPOUSE EMPLOYER				OCCUPATION
WORK ADDRESS : STREET	CITY	STATE	ZIP		WORK PHONE
EMERGENCY PERSON WE CAN CONTACT TO AUTHORIZE EMERGENCY CARE (OTHER THAN YOUR FAMILY HOME) NAME		WORK PHONE		HOME PHONE	
NAMES OF OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE			WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		

DENTAL INSURANCE INFORMATION

(PLEASE COMPLETE IF PATIENT HAS DENTAL INSURANCE)

PRIMARY INSURANCE COVERAGE:	INSURANCE COMPANY NAME	INSURANCE ADDRESS		
SUBSCRIBER'S NAME	SSN	DATE OF BIRTH	*PATIENT'S* RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
GROUP/PROGRAM #	UNION OR LOCAL #	EMPLOYER (*IF DIFFERENT FROM ABOVE)* : NAME	ADDRESS	
SECONDARY COVERAGE: ☐ NO ☐ YES	INSURANCE COMPANY NAME	INSURANCE ADDRESS		
SUBSCRIBER'S NAME	SSN	DATE OF BIRTH	*PATIENT'S* RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
GROUP/PROGRAM #	UNION OR LOCAL #	EMPLOYER (IF DIFFERENT FROM ABOVE) : NAME	ADDRESS	

INFORMATION RELEASE AND INSURANCE ASSIGNMENT :

I authorize the dentist to release any information required for administration of my treatment and/or completion of my insurance claims. I authorize that my records can be used by the doctor if he so determines.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due.

In consideration of the service rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policies.

I consent to the taking of photographs and diagnostic x-rays (only if needed for treatment) before, during and after treatment, and to the use of same by doctor in scientific papers or demonstrations.

I certify that I have read, or have had read to me, the contents of this form and do realize the risks and limitations involved.

Signature:_____ Date:_____

1/03

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby request that my dental records be released *from*:

____

(Name of *previous* Dentist/Dental Office)

____

(Street Address of *previous* Dentist/Dental Office)

____

(City, State, Zip of *previous* Dentist/Dental office)

To:

Dr. Kjersten A. Heron PLLC DBA Division Street Dental
104 North 15th Street, Mount Vernon, Washington 98273
360-424-9045

Please email most recent BWX, FMX, Pano, and Periodontal Charting the following to:
Office@SkagitDental.com

SPECIFICALLY INCLUDE:

- Films as **individual** image files
- Date(s) films were taken

PRINT: PATIENT NAME ____

Date of Birth: ______________________

Patient Signature: ____________________________________ Date: ______________________

IF MINOR, *under* age 14, parent or legal guardian signature required: ____________________________

* *

If a patient has reached his/her 14th birthday, only the patient may authorize disclosure as noted below:

CONSENT OF MINOR (Age 14 - 17)

I understand that I am entitled to confidential treatment of information relating to treatment for contraception, pregnancy, pregnancy termination, sterilization, sexually transmitted disease, mental health conditions, alcoholism or drug abuse. I further understand that my signature will authorize release of this information.

Authorizing Signature: ____________________________________ Date: ______________________

This authorization expires 90 days after the date it is signed.

Division Street Dental

Dr. Kjersten Heron
Dr. Victoria Otterholt
Dr. Dana Otterholt

CONSENT TO LEAVE MESSAGES

I understand that my healthcare information is protected. I understand that, in order for Division Street Dental to leave detailed messages containing specific dental information on my voice mail or answering machine, I need to give permission for them to do so.

Consent for Leaving Messages

I give my permission for messages to be left on my phone number(s) below:

- ☐ Cell # _____
- ☐ Home # _____
- ☐ Work #_____

OR

- ☐ I prefer not to have voice mail messages from the clinic

Regarding the following:

- ☐ Appointment Reminders/Changes
- ☐ Account Payments/Balances
- ☐ Cost Estimates
- ☐ Needed Treatment/Completed Treatment

It will be my responsibility to keep this information up to date, as I recognize that relationships and friendships may change over time. This consent will be considered valid until such time that I revoke it in writing. I reserve the right to revoke it at any time.

_____
Printed Name (Patient/Parent)

_____ _____
Signature (Patient/Parent) Date

Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron
Mt. Vernon, Washington 98273

STATEMENT OF PRIVACY PRACTICES

THIS STATEMENT OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ CAREFULLY

Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron collects and maintains a record of the health care services we provide you. In keeping with the Health Insurance Portability and Accountability Act (HIPAA), and the State of Washington, we are dedicated to protect your rights of privacy 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 will not disclose your protected health information unless you direct or authorize us to do so or unless it is otherwise allowed or compelled by law. 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.

You may see your record or get more information about it at "Your Individual Rights about Patient Health Information" section of the Notice. You may request to review and copy your personal record and you may also request that we make corrections to the record.

Overview

Our Statement of Privacy Practices is currently in effect and provides information about the use and disclosure of protected health information by Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron and our employees. It is applicable in all instances wherein individually identifiable health information is collected from you and services are provided for you. Our Statement:

1. Defines your rights and our obligations when using your health Information,
2. Informs you about laws that provide special protections,
3. Explains how your protected health information is used and how, under certain circumstances, it may be disclosed,
4. Tells you how changes in this statement will be made available to you.

In synopsis form, you have a right to:

1. Request restricted use of your health information. (Please understand that we may not agree to your request),
2. Request that we not disclose to your health plan of services for which you self-pay in full,
3. Request that we communicate with you by alternate methods,
4. Review and receive copies of your personal health record,
5. Request for amendments and/or changes be made to your record,
6. Request an accounting of disclosures of your health information,
7. File complaints related to failure to protect of privacy of your health information,
8. Direct us not to share information with your family members,

9. Request that you not be listed in/on our facility directory.

Protected Healthcare Information

It is important that you know not only that we limit requests for your personal information to that needed to provide quality health care, implement payment activities, and conduct normal health practice operations, but understand what "Protected Healthcare Information" is. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, and/or any personal information that is unique to you.

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.

Protecting your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the HIPAA and the state of Washington. This includes when it is used and disclosed to perform treatment, obtain payment, and conduct operational activities. 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 Statement of Privacy Practices applies to all personal health information collected or created by Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron or received from outside healthcare providers. This information may identify you, relate to your past, present or future physical or mental condition, the care provided, or any reference to payment for your health care.

For example, protected health information includes symptoms, test results, diagnoses, health information from other providers, as well as billing and payment information relating to these services. This information is protected because it is often part of your health or medical record, which we can use as:

1. A method of communication among health professionals who contribute to your care,
2. A legal record describing the care you received,
3. A means by which you can verify that services billed were provided,
4. A tool to educate health professionals,
5. A source of data for medical research,
6. A source of information for public health officials,
6. A source of information for facility planning,
8. A tool to assess and improve the care we provide,
9. A method by which we can provide a better understanding of your record,
10. A method by which we can ensure your record's accuracy,
11. A system to assist you to more clearly understand the circumstances and conditions in and by which others may have access to your personal information.

12. At tool for us to make more informed decisions when authorizing disclosures to others.

Use and Disclosure of your Protected Health Information - Without your Authorization

As stated above we may, under allowed circumstances use and disclose protected health information (PHI) without your specific authorization. Examples of such instances are included below:

Treatment: We may use and disclose your PHI to provide treatment. For example, we can:

1. Use your information to find out whether certain tests, therapies, and medicines should be ordered,
2. Provide your information to staff members to better understand what your healthcare needs are how to evaluate your response to treatment,
3. Disclose your PHI to another one of your treatment providers in the in order to provide you with the best possible health care.

Payment: We may use your health information for payment purposes. Such instances may include:

1. Preparation of claims for payment of services,
2. Billing your insurance directly, including information that identifies you, as well as your diagnosis, the procedures performed, and supplies used so that we can be paid for the treatment provided,
3. Collection activities (if necessary) to obtain payment for services.

Health Care Operations: We may use and disclose your health information to support the daily activities related to health care. Examples include:

1. Use and disclosure to monitor and improve our health services.
2. Use by authorized staff to review at portions of your record to perform administrative activities.

Train Staff and Students: We may use and disclose your information to teach and train staff how to review patient health information.

Contact You for Information: Your PHI may also be used to contact you. In example, we may call you or send you a letter to remind you about your appointment, provide test results, inform you about treatment options, or advise you about other health-related benefits and services.

Business Associates. Your PHI may be used by the Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron and disclosed to individuals, organizations, or companies that us or to comply with our legal obligations as described in this Notice. An example is disclosure of your PHI to consultants, attorneys or third parties to assist in our business activities. All such entities must sign a Business Associate Agreement to protect the confidentiality of your private information.

Additional Uses and Disclosures

We also use and disclose your information to enhance health care services, protect patient safety, safeguard public health, ensure that our facilities and staff comply with government and accreditation standards, and when otherwise compelled or allowed by law. For example, we provide or disclose information:

1. About FDA-regulated drugs and devices to the U.S. Food and Drug Administration.
2. To government oversight agencies with data for health oversight activities such as auditing or licensure.
3. To public health authorities with information on communicable diseases and vital records.
4. To your employer, findings relating to the evaluation of work-related illnesses or injuries.
5. To workers' compensation agencies and self-insured employers for work-related illness or injuries.
6. To appropriate government agencies when we suspect abuse or neglect.
7. To appropriate agencies or persons when we believe it necessary to avoid a serious threat to health or safety or to prevent serious harm.
8. To organ procurement organizations to coordinate organ donation activities.
9. To law enforcement when required or allowed by law, including the Office of Civil Rights to conduct OCR investigations.
10. For court order or lawful subpoena.
11. To coroners, medical examiners, and funeral directors.
12. To government officials when required for specifically identified functions such as national security.
13. When otherwise required by law, such as to the Secretary of the United States Department of Health and Human Services for purposes of determining compliance with our obligations to protect the privacy of your health information.
14. If you are a member of the armed forces, we may release medical information about you as required by military command authorities. We may also release medical information about foreign military
personnel to the appropriate foreign military authority.

Your Rights to Object

Disclosure to Family, Friends, or Others. You may object to our disclosing your general health condition ("good", "fair", "critical", etc.) to an individual, or individuals, you have identified who have an active interest in your care, payment for your health care, or who may need to notify others about your general condition, location, or death. If you do not so indicate, we will use our best professional judgment to provide relevant protected health information to your family member, friend, or another identified person.

Use and Disclosure Requiring Your Authorization

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.

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. You may revoke your written authorization, at

any time unless prohibited by law, or disclosure is required for us to obtain payment for services already provided, or we have otherwise relied on the authorization.

Additional Protection of Your Patient Health Information

Special state and federal laws apply to certain classes of patient health information. For example, additional protections may apply to information about sexually transmitted diseases, drug and alcohol abuse treatment records, mental health records, and HIV/AIDS information. When required by law, we will obtain your authorization before releasing this type of information.

Your Individual Rights about Patient Health Information

You may contact Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron to exercise your rights related to the use and disclosure of your protected health information. You may contact us at:

Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron
104 N. 15th Street
Mt. Vernon, Washington 98273
Attn: Drs. Otterholt and Dr. Heron
360-424-9045

Your specific rights are listed include:

1. **The right to request restricted use:** You may request in writing that we not use or disclose your information for treatment, payment, and/or operational activities except when authorized by you, when required by law, or in emergency circumstances. We are not legally required to agree to your request. If you request that we restrict the use of your private information, we will provide you with written notice of our decision about your request.
2. **The right to request non-disclosure to health plans:** You have the right to request in writing that health care items or services for which you self-pay for in full in advance of your visit not be disclosed to your health plan.
3. **The right to receive confidential communications:** You have the right to request that we communicate with you about medical matters in a particular way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request in writing to the address above. We will grant all reasonable requests. Your request must specify how or where you wish to be contacted.
4. **The right to inspect and receive copies:** In most cases, you have the right to inspect and receive a copy of certain health care information including certain medical and billing records. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.
5. **The right to request an amendment to your record:** If you believe that information in your record is incorrect or that important information is missing, you have the right to request in writing that we make a correction or add information. In your request for the amendment, you must give a reason for the amendment. We are not required to agree to the amendment of your record, but a copy of your request will be added to your record.
6. **The right to know about disclosures:** You have the right to receive a list of instances in which we have disclosed your health information. Certain instances will not appear on the list, such as disclosures for treatment, payment, or health care operations or when you have author-

ized the use or disclosure. Your first accounting of disclosures in a calendar year is free of charge. Any additional request within the same
calendar year requires a processing fee.

7. **The right to make complaints:** If you believe that we have violated your privacy, or you disagree with a decision we made about access to your records, you may file a complaint directly to Drs. Otterholt and Dr. Heron using the contact information above. Neither Drs. Otterholt and Dr. Heron, nor any employee of Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron will retaliate against anyone for filing a complaint.

You may also contact:

U.S. Department of Health and Human Services,
Office for Civil Rights:
2201 Sixth Avenue - Mail Stop RX-11
Seattle, WA 98121-1831
206-615-2290; 206-615-2296 (TTY)
206-615-2297 (fax)
Toll free: 1-800-362-1710; 1-800-537-7697 (TTY)

Breach Notification

If it is found that your patient information is used or disclosed in a manner that is not consistent with the practices described in this notice, Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron will fully investigate the matter to assess if there was a breach in the protection of your PPE. The assessment will be conducted to determine whether the information that was used or disclosed has significant risk of physical, financial, or reputational harm to you. If so, Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron will notify you and Health and Human Services in writing.

Privacy Notice Changes

We are required by law to protect the privacy of your information, to provide this Statement of Privacy Practices and to follow the privacy practices that are described herein. We reserve the right to change the privacy practices described and the right to make the revised or changed State ment effective for protected health information we already have as well as any information we may receive in the future.

We have posted a copy of our current Statement for your review and reference. Additionally, each time you visit our office for treatment or health care services, you may request a copy of our current Statement of Privacy Practices. An electronic version of the notice is posted at

PATIENT REGISTRATION

PLEASE COMPLETE THE FOLLOWING CONFIDENTIAL INFORMATION

PATIENT'S NAME: LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SSN
PATIENT'S HOME ADDRESS: STREET	CITY	STATE	ZIP		HOME PHONE
MARITAL STATUS S ☐ M ☐ D ☐ W ☐	PATIENT'S EMPLOYER			OCCUPATION	
WORK ADDRESS STREET	CITY	STATE	ZIP		WORK PHONE
PERSON FINANCIALLY RESPONSIBLE FOR THIS PATIENT ACCOUNT *(IF DIFFERENT FROM ABOVE)* NAME			RELATIONSHIP TO PATIENT: ☐ SPOUSE ☐ PARENT ☐ OTHER _____		
MAILING ADDRESS: STREET	CITY	STATE	ZIP		HOME PHONE
SPOUSE NAME	SPOUSE EMPLOYER			OCCUPATION	
WORK ADDRESS : STREET	CITY	STATE	ZIP		WORK PHONE
EMERGENCY PERSON WE CAN CONTACT TO AUTHORIZE EMERGENCY CARE (OTHER THAN YOUR FAMILY HOME) NAME			WORK PHONE		HOME PHONE
NAMES OF OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE			WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		

DENTAL INSURANCE INFORMATION

(PLEASE COMPLETE IF PATIENT HAS DENTAL INSURANCE)

PRIMARY INSURANCE COVERAGE:	INSURANCE COMPANY NAME		INSURANCE ADDRESS	
SUBSCRIBER'S NAME	SSN	DATE OF BIRTH	*PATIENT'S* RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
GROUP/PROGRAM #	UNION OR LOCAL #	EMPLOYER (*IF DIFFERENT FROM ABOVE)* : NAME	ADDRESS	
SECONDARY COVERAGE: ☐ NO ☐ YES	INSURANCE COMPANY NAME		INSURANCE ADDRESS	
SUBSCRIBER'S NAME	SSN	DATE OF BIRTH	*PATIENT'S* RELATION TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	
GROUP/PROGRAM #	UNION OR LOCAL #	EMPLOYER (IF DIFFERENT FROM ABOVE) : NAME	ADDRESS	

INFORMATION RELEASE AND INSURANCE ASSIGNMENT

I authorize the dentist to release any information required for administration of my treatment and/or completion of my insurance claims. I authorize that my records can be used by the doctor if she so determines.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due.

In consideration of the service rendered to me by this office, I am obligated to pay said office in accordance with its credit terms and policies.

I consent to the taking of photographs and diagnostic x-rays (only if needed for treatment) before, during and after treatment, and to the use of same by doctor in scientific papers or demonstrations.

I certify that I have read, or have had read to me, the contents of this form and do realize the risks and limitations involved.

CANCELLATION POLICY

I understand that changes to my appointment time need to be made with **24 hours** business notice, defined as **Monday-Thursday.** For example, changes to a Monday 8am appointment need to be made by 8am on Thursday the previous week. Changes with less than 24 hours notice (as defined above) will incur a $50 fee per half hour of time reserved for you. This policy will be strictly enforced. If your schedule frequently changes over the weekend, we do not recommend booking a Monday appointment.

Signature:_____ Date:_____

MEDICAL HISTORY

Patient Legal Name:_____ Preferred Name:_____ Date Of Birth:_____

Name of Physician:_____ Phone:_____

Date of Last Physician Visit:_____ Preferred Pharmacy:_____

CHECK IF YOU HAVE, OR HAVE HAD, THE FOLLOWING:

1. past hospitalization for illness or injury ..... ☐
2. presently being treating for any illness ..... ☐
3. allergic reaction to: ☐
   - ☐ aspirin ☐ penicillin ☐ erythromycin ☐ codeine ☐ local anesthetic ☐ fluoride
   - ☐ metals (gold, stainless steel) ☐ latex (rubber) products ☐ any other medications_____
4. hearing disorder or hearing aid ..... ☐
6. artificial prosthesis (e.g. joints, heart valve) ..... ☐
7. heart problems:
   - ☐ stroke date:_____
   - ☐ heart attack date:_____
   - ☐ angina
   - ☐ heart murmur
   - ☐ mitral valve prolapse
   - ☐ pacemaker
   - ☐ history of infective endocarditis
8. high blood pressure ..... ☐
9. anemia or other blood disorder ..... ☐
10. emphysema ..... ☐
11. asthma ..... ☐
12. tuberculosis ..... ☐
13. sinus problems ..... ☐
14. hives, skin rash, hay fever..... ☐
15. contact lenses ..... ☐
16. diabetes ..... ☐
17. kidney disease ..... ☐
18. liver disease ..... ☐
19. jaundice ..... ☐
20. hepatitis (type____) ..... ☐
21. thyroid or parathyroid disease ..... ☐
22. stomach or duodenal ulcer ..... ☐
23. arthritis ..... ☐
24. glaucoma ..... ☐
25. cigarette smoker, smokeless tobacco..... ☐
26. vape…… ☐
27. smoke marijuana ..... ☐
28. epilepsy, convulsions (seizures) ..... ☐
29. viral infections and cold sores ..... ☐
30. any lumps or swelling in the mouth ..... ☐
31. Tumor, cancer, abnormal growth
    - Type:_____ Date of diagnosis: _____
    - Please circle any treatment: Chemotherapy Radiation Surgery
    - Current cancer status:_____
32. AIDS or HIV positive ..... ☐
33. medicine for osteoporosis, osteopenia, or other..... ☐
34. alcohol/drug dependency ..... ☐
35. depression ..... ☐
36. often exhausted or fatigued ..... ☐

37. subject to frequent headaches ..... ☐
38. head or neck injuries……. ☐
39. anxiety ..... ☐
40. For females: Any you currently pregnant?..... ☐ If so, what trimester are you in:_____

Please describe any current medical treatment, impending surgery, or other treatment that may possibly affect your dental treatment

_____

Please list any medications (prescription or over the counter) you are taking now, or have taken within the last two years

_____

_____

_____

_____

SLEEP HEALTH

(circle your answers)

1. Do you snore?..... Yes No
2. How many times do you wake a night?..... 1 2 3 4+
3. Do you wake feeling rested?.....Yes No
4. If driving longer than 30 minutes do you struggle to stay awake?.....Yes No
5. Do you wear a nightguard?..... Yes No
6. Do you wear a snore guard?.....Yes No
7. Do you wear a CPAP?.....Yes No
8. Have you had your tonsils removed? …….Yes No
9. Once asleep do you struggle staying asleep? …….Yes No
10. Do you struggle to fall asleep? ……..…….Yes No

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGES IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature: _____ **Date**: _____

DENTAL HISTORY

Previous dentist: _____ City:_____ How long _____

Phone: _____ Date of last dental treatment _____

How often do you normally have your teeth checked and cleaned? 3 mo.____ 4 mo. ____ 6 mo. ____ 1 yr. or longer ____

WHAT IS YOUR IMMEDIATE DENTAL CONCERN?

_____

_____

PLEASE CHECK IF YOU HAVE, OR HAVE EVER HAD THE FOLLOWING:

1. unhappy with the appearance of your teeth..... ☐
2. unfavorable dental experience ..... ☐
3. dental fears..... ☐
4. preference for no dental anesthetic ..... ☐
5. problems with effectiveness or bad reactions to dental anesthetic ..... ☐
6. orthodontic treatment (braces) When? _____ ☐
7. periodontal (gum) treatment When? _____ ☐
8. bleeding gums ..... ☐
9. avoid brushing any part of your mouth ..... ☐
10. part of your mouth sensitive to temperature ..... ☐
11. sore teeth ..... ☐
12. a burning sensation in your mouth ..... ☐
13. difficulty swallowing..... ☐
14. an unpleasant taste or odor in your mouth ..... ☐
15. jaw problems (temporomandibular joint) ..... ☐
16. difficulty opening your mouth widely ..... ☐
17. stiff neck muscles ..... ☐
18. awaken with an awareness of your teeth or jaws..... ☐
19. tension headaches ..... ☐
20. clench or grind your teeth ..... ☐
21. jaw clicking or popping ..... ☐

SUPPLEMENTAL DENTURE HISTORY:

If you are wearing a partial or complete artificial denture, please complete the following:

The denture(s) I wear is (are) a: complete upper lower partial upper lower

When did you receive your *first* partial or complete denture?_____

How long have you worn your *present* denture? _____

Has your present denture been relined? When? _____

Is your present denture a problem? Describe _____

Satisfied with appearance? _____

Satisfied with comfort? _____

Satisfied with chewing ability? _____

Patient Signature _____ **Date** _____

Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron
Mt. Vernon, Washington 98273

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 Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron. 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.

Dr. Dana Otterholt, Dr. Vicki Otterholt, Dr. Kjersten Heron reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other: _____	☐ **YES**	☐ **NO**
Name of patient (please print): _____		
Patient signature (if 18 years old or older): _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided: _____**
Reason for not obtaining patient signature	☐	**Needed more time to review Statement of Privacy Practices**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	
	☐	**No reason offered**	
	☐	**Other:**	