Kirkland Endodontics

Boyd F. Munson, DMD, PS
Tom J. Rude, DDS, PS

Patient Confidential Information

First Name _____ **MI** _____ **Last Name** _____ **Nickname** _____

*** If Patient is a minor,**
Responsible party_____ **Relationship** _____**Contact #**_____

Billing Address_____ **City** _____ **State** ____ **Zip Code** _____

Home Phone _____ **Cell Phone**_____ **Work Phone** _____

Email _____

Employer _____ **Occupation** _____

Patient's Birth date Month _____ **Day**_____ **Year**_____ **Social Security #**_____

Check Appropriate Box: **Minor** _____ **Single** _____**Married** _____ **Divorced** _____**Widowed** _____

Spouse _____ **Employer** _____ **Occupation** _____

Emergency Contact Name _____ **Phone** _____

Referring Dentist _____ **How long have you been their patient?** _____

Your Estimated Portion is Due Upon Completion of Services,

How would you like to pay for today's visit? _____ **(Cash, Credit Card etc…)**

You Are Financially Responsible for Any Services at This Office

As a courtesy to our patients we are happy to file your Insurance Claim. PLEASE REMEMBER THAT THE INSURANCE CONTRACT IS BETWEEN YOU AND YOUR INSURANCE CARRIER. Assignment & Release: I authorize the dentist or insurance company to release information required for payment or review of this treatment. I authorize payment of benefits, otherwise payable to me to be paid directly to the dentist.

Signature of patient (or guardian) _____ **Date** _____

Insurance Information

Primary Dental Insurance _____ **Group** _____

Name of Insured _____ **Relationship to Patient** _____

Insured's Birth Date Month _____ **Day**_____ **Year**_____ **SS# or Id#** _____

Insured's Employer _____ **Ins. Co Phone** _____

Ins. Co. Address _____ **City** _____ **St** _____ **Zip** _____

Secondary Insurance Information

Secondary Dental Insurance _____**Group**_____

Name of Insured _____ **Relationship to Patient** _____

Insured's Birth date Month _____ **Day**_____ **Year**_____ **SS# or Id#** _____

Insured's Employer _____ **Ins. Co Phone** _____

Ins. Co Address _____ **City** _____ **St** _____ **Zip** _____

Health History Form

Email: Today's Date:

KIRKLAND ENDODONTICS

As required by law, our office adheres to written policies and procedures to protect the privacy of information about you that we create, receive or maintain. Your answers are for our records only and will be kept confidential subject to applicable laws. Please note that you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health. This information is vital to allow us to provide appropriate care for you. This office does not use this information to discriminate.

Name: *First* *Middle* *Last*	Home Phone: *Include area code* ( )	Business/Cell Phone: *Include area code* ( )
Address: *Mailing address*	City:	State: Zip:
Occupation:	Height: Weight:	Date of Birth:
Current Gender Identity: Male Female Other/specify		Decline
SS# or Patient ID: Emergency Contact:	Relationship:	Home Phone: *Include area code* ( ) Cell Phone: *Include area code* ( )

If you are completing this form for another person, what is your relationship to that person?

Your Name *Relationship*

Do you have any of the following diseases or problems: *(Check DK if you Don't Know the answer to the question)*	Yes	No	DK
Active Tuberculosis	☐	☐	☐
Persistent cough greater than a 3 week duration	☐	☐	☐
Cough that produces blood	☐	☐	☐
Been exposed to anyone with tuberculosis	☐	☐	☐

If you answer yes to any of the 4 items above, please stop and return this form to the receptionist.

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

	Yes	No	DK
Are you now under the care of a physician?	☐	☐	☐
Physician Name: Phone: *Include area code* ( )			
Address/City/State/Zip:			
Are you in good health?	☐	☐	☐
Has there been any change in your general health within the past year?	☐	☐	☐
If yes, what condition is being treated?			
Date of last physical exam:			

	Yes	No	DK
Have you had a serious illness, operation or been hospitalized in the past 5 years?	☐	☐	☐
If yes, what was the illness or problem?			
Are you taking or have you recently (last 12 months) taken any prescription or over the counter medicine(s)?	☐	☐	☐
If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:			

Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

(Check DK if you Don't Know the answer to the question)	Yes	No	DK
Joint Replacement. Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement?	☐	☐	☐
Date: _____ If yes, have you had any complications? _____			
Are you taking or scheduled to begin taking an antiresorptive agent (like Fosamax®, Actonel®, Atelvia, Boniva®, Reclast, Prolia) for osteoporosis or Paget's disease?	☐	☐	☐
Since 2001, were you treated or are you presently scheduled to begin treatment with an antiresorptive agent (like Aredia®, Zometa®, XGEVA) for bone pain, hypercalcemia or skeletal complications resulting from Paget's disease, multiple myeloma or metastatic cancer?	☐	☐	☐
History of alcohol or drug abuse?	☐	☐	☐
Date Treatment began: _____			

	Yes	No	DK
Do you use marijuana?	☐	☐	☐
Do you drink alcoholic beverages?	☐	☐	☐
If yes, how much alcohol did you drink in the last 24 hours? _____			
If yes, how much do you typically drink i n a week? _____			
WOMEN ONLY Are you:			
Pregnant?	☐	☐	☐
Number of weeks: _____			
Taking birth control pills or hormonal replacement?	☐	☐	☐
Nursing?	☐	☐	☐

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Medical Information *Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.*

Allergies. Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.

	Yes	No	DK
Local anesthetics (novocaine) _____	☐	☐	☐
Aspirin, acetaminophen, ibuprofen _____	☐	☐	☐
Penicillin or other antibiotics _____	☐	☐	☐
Barbiturates, sedatives, or sleeping pills _____	☐	☐	☐
Sulfa drugs _____	☐	☐	☐
Codeine or other narcotics, hydrocodone, oxycodone _____	☐	☐	☐
Metals _____	☐	☐	☐
Latex (or rubber dam) _____	☐	☐	☐
Iodine _____	☐	☐	☐
Hay fever/seasonal _____	☐	☐	☐
Food _____	☐	☐	☐
Other _____	☐	☐	☐

Please mark (X) your response to indicate if you have or have not had any of the following diseases or problems.

	Yes	No	DK
Artificial (prosthetic) heart valve	☐	☐	☐
Previous infective endocarditis	☐	☐	☐
Damaged valves in transplanted heart	☐	☐	☐
Congenital heart disease (CHD)			
Unrepaired, cyanotic CHD	☐	☐	☐
Repaired (completely) in last 6 months	☐	☐	☐
Repaired CHD with residual defects	☐	☐	☐

Except for the conditions listed above, antibiotic prophylaxis is no longer recommended for any other form of CHD.

	Yes	No	DK
Cardiovascular disease	☐	☐	☐
Angina	☐	☐	☐
Arteriosclerosis	☐	☐	☐
Congestive heart failure	☐	☐	☐
Damaged heart valves	☐	☐	☐
Heart attack	☐	☐	☐
Heart murmur	☐	☐	☐
Low blood pressure	☐	☐	☐
High blood pressure	☐	☐	☐
Other congenital heart defects	☐	☐	☐
Mitral valve prolapse	☐	☐	☐
Pacemaker	☐	☐	☐
Rheumatic fever	☐	☐	☐
Rheumatic heart disease	☐	☐	☐
Abnormal bleeding	☐	☐	☐
Anemia	☐	☐	☐
Blood transfusion	☐	☐	☐
If yes, date: _____			
Hemophilia	☐	☐	☐
AIDS or HIV infection	☐	☐	☐
Arthritis	☐	☐	☐

	Yes	No	DK
Autoimmune disease	☐	☐	☐
Rheumatoid arthritis	☐	☐	☐
Systemic lupus erythematosus	☐	☐	☐
Asthma	☐	☐	☐
Emphysema	☐	☐	☐
Sinus trouble	☐	☐	☐
Tuberculosis	☐	☐	☐
Cancer/Chemotherapy/ Radiation Treatment	☐	☐	☐
Chest pain upon exertion	☐	☐	☐
Chronic pain	☐	☐	☐
Diabetes Type I or II	☐	☐	☐
Gastrointestinal disease	☐	☐	☐
G.E. Reflux/persistent heartburn	☐	☐	☐
Ulcers	☐	☐	☐
Thyroid problems	☐	☐	☐
Stroke	☐	☐	☐

	Yes	No	DK
Glaucoma	☐	☐	☐
Hepatitis, jaundice or liver disease	☐	☐	☐
Epilepsy	☐	☐	☐
Fainting spells or seizures	☐	☐	☐
Neurological disorders	☐	☐	☐
If yes, specify: _____			
Mental health disorders	☐	☐	☐
Specify: _____			
Recurrent Infections	☐	☐	☐
Type of infection: _____			
Kidney problems	☐	☐	☐
Osteoporosis	☐	☐	☐
Persistent swollen glands in neck	☐	☐	☐
Severe headaches/ migraines	☐	☐	☐
Sexually transmitted disease	☐	☐	☐

Has a physician or previous dentist recommended that you take antibiotics prior to your dental treatment? ☐ ☐ ☐

Name of physician or dentist making recommendation:

Phone: *Include area code*
( )

Do you have any disease, condition, or problem not listed above that you think I should know about? ☐ ☐ ☐
Please explain:

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian: Date:

Signature of Dentist: Date:

FOR COMPLETION BY DENTIST

Comments:

Kirkland Endodontics

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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 individual identifiable health care 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 your 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 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 healthcare operations.

Treatment means providing, coordination, 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 collections activities, and utilization review. For example, treatment information is disclosed 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 reviewed periodically for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, 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 or to pre-medicate by sending reminder postcards or leaving messages at your home/work or cell. Any other uses or 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 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 members, other relatives 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 rights to access inspect and copy your protected health care 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, or health care operations.
- The right to obtain a paper copy of this notice from us on request.
- The have the right to be notified if a breach of your unsecured PHI occurs.
- We are prohibited by law from using PHI that is genetic information for underwriting purposes.

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 care 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 listed below, or with the Department of Health and 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 please contact:

Michela von Borries, Privacy Officer
Munson and Rude PS
11830 NE 128th St Suite 101
Kirkland, WA 98034
425 821-7100

For more information about HIPAA or to make a complaint:

The US Dept. of Health and Human Services, Office of Civil Rights
200 Independence Ave
Washington DC 20201
877-696-6775 (toll free)

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Acknowledgement of Privacy Practices

11830 NE 128th St. Suite 101
Kirkland, WA 98034
(425) 821-7100
FAX (425) 820-8208
info@KirklandEndodontics.com

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:

- ☐ Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly
- ☐ Obtain payment from third-party payers for my health care services
- ☐ Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's Notice of Privacy Practices containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such Notice of Privacy Practices. 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 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 and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name _____ Date _____

Signature _____

Relationship to patient _____

Please list other persons with whom we may share your Protected Health Information:

_____

_____

For office use only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Rights for the following reason:

- Patient refused to sign
- Communication barriers
- Emergency situation
- Other