a harbor tradition | KVINSLAND DENTISTRY

253.851.9171
kvinslanddentistry.com

Referred By _____ Date _____

Name_____ Date of Birth _____ ☐ M ☐ F

Res. Phone _____ Cell Phone_____ Text OK? ☐ Yes ☐No Email: _____

Mailing Address _____ City _____ State _____ Zip _____

Previous Address _____ City _____ State _____ Zip _____

SSN _____ Employer/Occupation_____ Bus. Phone _____

Spouse's Name _____ Employer/Occupation_____ Best Phone_____

Spouse's SSN_____ Birth date_____ Nearest Friend/Relative _____ Best Phone_____

Primary Ins. _____ Group # _____ Subscriber ID_____

Secondary Ins. _____ Group # _____ Subscriber ID_____

Person Responsible for Acct_____ Address _____

Chief Oral Complaint _____

Date of Last Exam_____ Any Previous Major Dental Treatment? _____ When?_____

DENTAL HISTORY: Do you have any of the following? *(Check all that apply)*

☐ Concerns with appearance of teeth	☐ Removable dental appliance	☐ Complications from extractions
☐ Teeth sensitive to cold, hot, sweets or pressure	☐ Swelling or lumps in mouth	☐ Periodontal treatment
☐ Bleeding gums	☐ Unpleasant taste	☐ Orthodontic treatment
☐ Food impaction	☐ Pain around ear	☐ Mouth breathing
☐ Clenching or grinding	☐ Unusual sounds in ear while eating	☐ Unpleasant dental experience
☐ Bad breath	☐ Night guard	☐ Other _____

HEALTH HISTORY

Name of Physician		Phone		Date of Last Physical	

Are you presently ill or under the care of a physician? ☐ Yes ☐ No If yes, describe:

Do you have, or have you had: *(Please check to the RIGHT of each item)*	Y	N	Don't Know		Y	N	Don't Know		Y	N	Don't Know
Heart problems or Angina				Glaucoma				Diabetes			
High blood pressure				Cold sores (Herpes)				Thyroid disease			
Rheumatic fever				Persistent cough				HIV positive/AIDS			
Heart murmur				Emphysema				Arthritis			
Heart Surgery				Tuberculosis				Painful joints (includes jaw)			
Prosthetic heart valve(s)				Asthma				Prosthetic joint(s)			
Pacemaker				Sinus problems				Drug addiction			
Hepatitis type:				Anemia				Alcoholism			
Liver disease				Hemophilia				Psychiatric/Emotional problems			
Yellow jaundice				Bruise or bleed easily				Cancer/Radiation therapy			
Epilepsy or seizures				Ulcers				Sleep Disorders/Apnea			
Fainting or dizziness				Kidney problems				Acid Reflux			
Stroke				Venereal disease							

ALLERGIES (Please list ALL allergies, include environmental, medications, antibiotics, food, etc...)

Do you use any tobacco products? ☐ Yes ☐ No Describe: _____

Describe any current medication, condition, medical treatment not listed above (including aspirin, BC pill, hormone therapy, etc.):

_____

_____

I acknowledge that I am financially responsible for all charges whether or not paid by insurance. If it becomes necessary to effect collections of balance due, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.

Signature _____ Date_____

FOR OFFICE USE ONLY: Revised Information

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Acknowledgement of Privacy Practices

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 providers *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:_____

Dependent family members also covered by this acknowledgement:

_____

_____

_____

For Office Use Only:

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

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other

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Authorization to Release Health Care Information

Patient's name:_____Date of Birth:_____

I request and authorize _____ to release health care information of the patient name above to:

Kvinsland Dentistry
5122 Olympic Dr. A-201
Gig Harbor, WA 98335

info@kvinsland dentistry.com | 253.851.9171

This request and authorization applies to:

- ☐ Health care information relation to the following treatment, condition, or dates of treatment:
  _____
- ☐ All health care information
- ☐ Other: _____

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to relase all health care information relating to such diagnosis, testing, or treatment.

Patient Name:_____ Date:_____

Signature:_____

Relationship to Patient:_____

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Welcome to Kvinsland Dentistry! Thank you for selecting our office for your dental care. We are committed to providing excellent dental care with concern for your personal needs. The following information will acquaint you with our office financial policies and allow us to provide a high quality of service to you.

- **Insurance Benefits:** We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We cannot guarantee the payments level that is quoted nor have information on benefits used in any other dental professionals office if used within your plan year. Any balances remaining after your insurance pays, are due within 15 days of billing.

- **Payment:** Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patient CO-PAYMENTS and DEDUCTIBLES are due at the time of service, unless other arrangements are made. A service charge of 1.0% per month (12% APR) or $8.00, whichever is greater, will be added to your account for balances due past 30 days.

- **Minor Patients:** The adult accompanying the minor (under the age of 18) is responsible for full payment of the services provided. A parent or legal guardian MUST accompany the minor unless prior arrangements have been made.

- **Missed Appointments:** For the courtesy of other patients that are waiting for appointment times, please be aware that we require a 24 hour notice to change or cancel an appointment to avoid a charge.

PAYMENT OPTIONS:

1. Complete payment in advance: For qualified patients we offer a **5% bookkeeping courtesy reduction** when the total amount for all phases of your proposed treatment plan is paid in full by **cash or check** BEFORE the first appointment.
2. We accept: **VISA, MASTERCARD, CASH, OR CHECK**
3. Healthcare Financing: Upon approval of credit, including a 12 month option.

CONSENT FOR CARE:

I request the consultation services of Eric Kvinsland, DDS or Amelia Skifstad, DDS.. I authorize the doctor to take any necessary x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor to make thorough diagnosis of treatment needs. I understand this may include consultation with my physician or other practice specialists. I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.

_____ _____

Date Patient Name- Printed

_____

Patient Signature (Parent if under 18)