KELCEY RHODES, DDS
THOMAS RHODES, DDS
tel 253.845.0520 fax 253.770.8643

Main Station
DENTAL

111 West Main Street
Puyallup, WA 98371
scheduling@rhodesdentistry.com

PATIENT DENTAL HISTORY

PATIENT'S NAME______________________________DATE OF BIRTH____________________
REASON FOR THIS VISIT____
WHEN WAS YOUR LAST DENTAL VISIT______________WHAT WAS DONE THEN____________________
PREVIOUS DENTIST (NAME ANDLOCATION) ______________________________________
HAVE YOU HAD A COMPLETE SERIES OF DENTAL XRAYS TAKEN? ________WHEN AND WHERE________________
HOW OFTEN DO YOU BRUSH YOUR TEETH_____HOW OFTEN DO YOU FLOSS YOUR TEETH? ______________
IS YOUR DRINKING WATER FLUORIDATED? ______________

DO YOUR GUMS BLEED WHEN YOU BRUSHING OR FLOSSING	YES	NO
ARE YOUR TEETH SENSITIVE TO HOT OR COLD LIQUIDS/FOODS?	YES	NO
ARE YOUR TEETH SENSITIVE TO SWEET OR SOUR LIQUIDS/FOODS?	YES	NO
DO YOU FEEL PAIN IN ANY OF YOUR TEETH?	YES	NO
DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH?	YES	NO
HAVE YOU HAD ANY HEAD, NECK OR JAW INJURIES?	YES	NO
HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING PROBLEMS IN YOU JAW?	YES	NO

CLICKING PAIN (JAW, JOINT, EAR, SIDE OF FACE)
DIFFICULTY OPENING OR CLOSING DIFFICULTY CHEWING

DO YOU HAVE FREQUENT HEADACHES?	YES	NO
DO YOU CLENCH OR GRIND YOUR TEETH?	YES	NO
HAVE YOU NOTICED ANY LOOSE TEETH?	YES	NO
DOES FOOD TEND TO BECOME CAUGHT BETWEEN YOUR TEETH?	YES	NO
HAVE YOU EVER HAD PERIODONTAL TREATMENT (FOR GUM DISEASE)?	YES	NO
EVER WORN A BITE PLATE OR OTHER APPLIANCE?	YES	NO
HAVE YOU EVER HAD PROLONGED BLEEDING AFTER AN EXTRACTION?	YES	NO
DO YOU WEAR DENTURES OR A PARTIAL DENTURE?	YES	NO

DATE OF PLACEMENT______________

IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD YOU CHANGE? ____________________

SLEEP QUESTIONNAIRE

HAVE YOU EVER BEEN DIAGNOSED WITH SLEEP APNEA?	YES	NO
HAVE YOU EVER HAD AN OVERNIGHT SLEEP STUDY?	YES	NO

IF YES, WHEN?____________WHERE?______________________________

DO YOU WAKE UP IN THE MORNING WITH A HEADACHE?	YES	NO
HAS ANYONE EVER TOLD YOU THAT YOU CLENCH OR GRIND YOUR TEETH?	YES	NO
DO YOU SNORE?	YES	NO
HAVE YOU EVER BEEN TOLD YOU GASP FOR AIR OR SUDDENLY STOP BREATHING WHILE SLEEPING?	YES	NO
DO YOU OR HAVE YOU USED A CPAP?	YES	NO

IF YES, HOW MANY NIGHTS PER WEEK?______________
WHAT IS YOUR NECK SIZE?________________________

DO YOU WAKE UP REFRESHED MOST DAYS OF THE WEEK?	YES	NO
ARE YOU EXCESSIVELY TIRED DURING THE DAY?	YES	NO

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PATIENT NAME____TODAY'S DATE______/______/______
First Last Middle

PATIENT ADDRESS____
Street City State Zip

HOME PHONE____________________MOBILE PHONE____________________WORK PHONE____________________

EMAIL ADDRESS: ______________________________________

PATIENT BIRTHDAY______/______/______ AGE______ GENDER [ ] Male [ ] Female SOCIAL SECURITY #____________________

PATIENT EMPLOYER________________________________PATIENT OCCUPATION____________________

PATIENT'S MARITAL STATUS [ ] Single [ ] Married Spouse's Name__________________________

PATIENT'S RELATIONSHIP TO PERSON PRIMARILY RESPONSIBLE FOR PAYMENT [ ] SELF [ ] SPOUSE [ ] CHILD [ ] Dependent

Whom may we thank for REFERRING you? [ ] Drive-by [ ] another Patient__________________________ [ ] Internet [ ] Local Paper_______ [ ] Other____________________

EMERGENCY CONTACT (a local friend or relative)____

CONTACT'S PHONE NUMBERS____ RELATIONSHIP TO YOU____________________

PRIMARY RESPONSIBLE PARTY TO PAY FOR PATIENT'S DENTAL SERVICES & TO RECEIVE BILLING STATEMENTS

NAME____ RELATIONSHIP TO PATIENT [ ] SELF OTHER____________________
MARITAL STATUS [ ] Single [ ] Married GENDER [ ] Male [Female

ADDRESS____ HOME PHONE____________________

____ WORK PHONE____________________

City State Zip SOCIAL SECURITY #____________________

BIRTHDAY______/______/______ EMPLOYER______________________________ OCCUPATION____________________

EMPLOYER'S ADDRESS____
Street Address City State Zip

DENTAL INSURANCE INFORMATION (if applicable)

**** NOT a Medicare Provider ****

INSURANCE COMPANY____________________	2NDARY INSURANCE CO.____________________
EFFECTIVE DATE__________ PHONE__________	EFFECTIVE DATE__________ PHONE__________
INSURANCE ADDRESS____________________	ADDRESS____________________
City State Zip	City State Zip
SUBSCRIBER'S NAME____________________	SUBSCRIBER'S NAME____________________
____/____/____ Subscriber's Birthdate; ____________ Subscriber's Social Security Number	____/____/____ Subscriber's Birthdate; ____________ Subscriber's Social Security Number
____________ GROUP NUMBER; ____________ Subscriber's ID Number	____________ GROUP NUMBER; ____________ Subscriber's ID Number
RELATIONSHIP TO SUBSCRIBER [ ] Self [ ] Spouse [ ] Child [ ] Dependent	RELATIONSHIP TO SUBSCRIBER [ ] Self [ ] Spouse [ ] Child [ ] Dependent
SUBSCRIBER'S EMPLOYER____________________	SUBSCRIBER'S EMPLOYER____________________

Please sign the other side➔➔➔

PAYMENT OPTIONS

Our goal is to provide our patients with the finest and most comprehensive dental care possible. We will work with you to create the best treatment plan that fits within your financial expectations.

We will clearly explain your treatment options and give you a written financial estimate. Any changes in treatment or fees will be discussed as it occurs.

Payment is due at the time service is performed, unless arrangements have been made in advance.

Payment for your dental treatment is due at the time of treatment. We understand that some patients may not be able to (or may not desire to) pay cash for their treatment. Therefore, we offer several different payment types for your convenience to pay for your treatment.

1) Cash or Check
2) Visa or MasterCard
3) Care Credit Financing (no interest option, approval required by CareCredit)
   - If interested, please ask for an application.

MISSED APPOINTMENT FEES, INTEREST & LATE CHARGES, NSF CHECK FEES

I acknowledge that a $50 charge will be assessed for each hour of a missed appointment not cancelled at least 48 business hours in advance. I also acknowledge that a late charge of 1.5% per month, at a rate of 18% per year, with a minimum charge of $1.00 per month, will be charged on all unpaid account balances that are 30 days past due. I also acknowledge that a $25 charge will be assessed for any "NSF" checks (i.e., checks not paid by my bank due to non-sufficient funds or for "stop payment"). I realize that failure to keep my account current in payment will result in this office being unable to provide me additional dental services. In the case of this account being sent to a collection agency for a past due balance, I agree to pay all collection agency costs, reasonable attorneys fees, and legal expenses incurred to collect such past due balance.

AUTHORIZATION, RELEASE, AND ACKNOWLEDGEMENT OF FINANCIAL POLICY

1. I authorize your office to release any information related to my dental treatment, including any diagnosis and records or x-rays of any treatment or examination rendered to me during the period of such dental care, to any third party payors, insurance companies, and/or other health and dental practitioners.

2. I authorize and request my insurance company, if any, to pay directly to your office the insurance benefits otherwise payable to me. I understand that your office is providing a courtesy to me by allowing me to assign my insurance benefits to your dental office, and that your office may terminate this courtesy at any time.

3. I understand that my dental insurance company and/or my primary responsible party may pay less than the actual bill for services. I agree to be solely responsible for full payment of all services rendered on my behalf or on behalf of my dependents should for any reason my insurance company and/or my primary responsible party fail to pay or pay less than full for such services.

4. I acknowledge that I have reviewed your office's Financial Policy.

5. I understand that Dr. Rhodes is NOT contracted with Medicare.

X____ ____________________

Signature of Patient (or Signature of Parent/Guardian if a minor patient) Date

THANK YOU for filling out this form completely and reviewing our above office policies. The information you have provided will help us serve you dental healthcare needs more effectively and efficiently. If you have any questions at any time, please ask us. We are always happy to help.

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NOTICE OF PRIVACY PRACTICES

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

We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect September 23, 2013, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law, and to make new Notice provisions effective for all protected health information that we maintain. When we make a significant change in our privacy practices, we will change this Notice and post the new Notice clearly and prominently at our practice location, and we will provide copies of the new Notice upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. For each of these categories, we have provided a description and an example. Some information, such as HIV-related information, genetic information, alcohol and/or substance abuse records, and mental health records may be entitled to special confidentiality protections under applicable state or federal law. We will abide by these special protections as they pertain to applicable cases involving these types of records.

Treatment: We may use and disclose your health information for your treatment. For example, we may disclose your health information to a specialist providing treatment to you. This may include photos of your teeth and face only for the purpose of providing necessary dental treatment.

Payment: We may use and disclose your health information to obtain reimbursement for the treatment and services you receive from us or another entity involved with your care. Payment activities include billing, collections, claims management, and determinations of eligibility and coverage to obtain payment from you, an insurance company, or another third party. For example, we may send claims to your dental health plan containing certain health information.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. For example, healthcare operations include quality assessment and improvement activities, conducting training programs, and licensing activities.

Individuals Involved in Your Care or Payment for Your Care: We may disclose your health information to your family or friends or any other individual identified by you when they are involved in your care or in the payment for your care. Additionally, we may disclose information about you to a patient representative. If a person has the authority by law to make health care decisions for you, we will treat that patient representative the same way we would treat you with respect to your health information.

Disaster Relief: We may use or disclose your health information to assist in disaster relief efforts.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Public Health Activities: We may disclose your health information for public health activities, including disclosures to:
o Prevent or control disease, injury or disability;
o Report child abuse or neglect;
o Report reactions to medications or problems with products or devices;
o Notify a person of a recall, repair, or replacement of products or devices;
o Notify a person who may have been exposed to a disease or condition; or
o Notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody the protected health information of an inmate or patient.

Secretary of HHS: We will disclose your health information to the Secretary of the U.S. Department of Health and Human Services when required to investigate or determine compliance with HIPAA.

Worker's Compensation. We may disclose your PHI to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Law Enforcement: We may disclose your PHI for law enforcement purposes as permitted by HIPAA, as required by law, or in response to a subpoena or court order.
Health Oversight Activities: We may disclose your PHI to an oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections, and credentialing, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

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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 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.* Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule.

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:

____

Additional Disclosure Authority: (concluded with discussion RE: patient etc.)
OTHER-SPECIFY Names Signatures ID

____
____
____
____

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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PHOTOGRAPH CONSENT

I, ____________________________ give my consent to Kelcey Rhodes PLLC dba Rhodes Dentistry and her staff to take radiographs of dentition and/or photographs of the head and neck areas, including the profile, face, teeth, smile, and intraoral features, pre-, during, and post treatment of ____________________________ for the purposes of internal office use in dental records or for use in treatment planning, education, publication in professional journals, and/or advertising. I understand that my identity will be blurred in most cases and that my personal information will be protected.

I hereby waive any right that I may have to inspect or approve the finished product(s) and advertising copy to which the photographs may be applied.

I hereby release, discharge, and agree to save harmless Kelcey Rhodes PLLC dba Rhodes Dentistry and all persons acting under her permission or authority or those for whom she is acting from any liability by virtue of any blurring, distortion, alteration, optical illusion, or use in composite form, whether intentional or otherwise, that may occur or be produced in the taking of said photograph or in any subsequent processing thereof, as well as any publications thereof, including without any limitation any claims for libel or invasion of privacy.

I have a right to restrict the use of photographic images as indicated here ____________________________________.

I hereby warrant that I am of legal age and have the right to contract my own name, or I am not of legal age and my parent/legal guardian whose signature is witnessed below is executing this release. I/my guardian has read the above consent prior to its execution, and I/my guardian am/is fully familiar with agreement.

Patient's Name (Print): ____ Date: _________________________

Signature:

____

Guardian (If under legal age): ____

Guardian Signature: ____