PATIENT INFORMATION

Date:_____

SS/PT ID #:_____

Patient Name:_____

Address:_____

City:_____State:_____Zip:_____

E-mail:_____

Sex:____Age:_____Birthdate:_____

Status: (Please Circle) Married Single Widowed

Minor Separated Divorced Partnered

PT Employer/School:_____

Occupation/Grade:_____

Work/School #:_____

Spouse/Partner Name:_____

Birthdate:_____SS/ID#:_____

Spouse/Partner Employer:_____

Whom may we thank for referring you?_____

_____

DENTAL INSURANCE

Who is responsible for the acct?_____

Relationship to PT?_____

Insurance Co:_____

Group#:_____ID#:_____

Subscriber's Name:_____

Birthdate:_____SS/ID#:_____

Relationship to PT?_____

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependent/s, have insurance coverage with:

_____

Name of insurance company

and assign directly to Dr. Lam-Gershony all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Lam-Gershony may use my health care information and may disclose such information to the above insurance company/ies and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services. The consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Signature of patient, parent, guardian or personal rep.

_____

Please print name of patient, parent, guardian or personal rep.

_____ _____

Date Relationship to patient

PHONE NUMBERS

Home:_____Work:_____Cell:_____Spouse's Work:_____

Best time & place to reach you at?_____Emergency Contact:_____

Relationship:_____Home #:_____Cell/Work #:_____

DENTAL HISTORY

Reason for today's visit:_____
Former Dentist:_____
City/State:_____Last Visit:_____
Are you currently in pain?_____
Have you had any problems w/ past dental work?_____
Have you had any serious head/mouth injury?_____
How do you feel about your smile?_____
Any problems with dental anesthetic? _____

MEDICAL HISTORY

Are you under the care of a physician?_____
Physician Name:_____
Phone #:_____
Are you in good health?_____
Has there been any changes in your general health w/in the last year?_____If yes, what?_____
Date of last physical exam:_____
Have you had a serious illness, operation or been hospitalized in the last 5 years?_____
If yes, what/why:_____

Patient Name: _____

HEALTH HISTORY

*Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of Lonimin, Adipex, Fastin (brand names of Phentermine). Pondimin (Fenfluramine) and Redux (Dexfenfluramine). Yes___No___.
*Are you taking or scheduled to begin taking either of the medications, Alendronate (Fosamax) or Risedronate (Actonel) for Osteoporosis or Paget's Disease? Yes___No___.
*Since 2001, were you treated or are you presently scheduled to begin treatment with the intravenous bisphosphonates (Aredia or Zometa) for bone pain, hypercalcemia or skeletal complications resulting from Paget's Disease, Multiple Myeloma or Metastatic Cancer? Yes___No___. Date treatment began:_____
*Have you ever had an orthopedic total joint (hip, knee, elbow, finger) replacement? Yes___No___. Date_____
*Do you use controlled substances (drugs)? Yes___No___. *Do you use tobacco (smoking, snuff chew, bidis)? Yes___No___.
*Do you drink alcoholic beverages? Yes___No___. If yes, how much alcohol did you drink in the last 24 hours?_____
If yes, how much do you typically drink in a week?_____

PLEASE CHECK TO INDICATE IF YOU HAVE HAD ANY OF THE FOLLOWING:

AIDS/HIV:	_____	Epilepsy:	_____	Pacemaker:	_____
Anemia:	_____	Excessive		Psychiatric Care:	_____
Arthritis:	_____	Bleeding:	_____	Radiation:	_____
Artificial Heart		Fainting:	_____	Respiratory Disease:	_____
Valve:	_____	Glaucoma:	_____	Rheumatic Fever:	_____
Artificial Joints:	_____	Headaches:	_____	Scarlet Fever:	_____
Asthma:	_____	Heart Murmur:	_____	Sinus Trouble:	_____
Back Problems:	_____	Heart Problems:	_____	Skin Rash:	_____
Blood Disease:	_____	Hepatitis		Stroke:	_____
Cancer:	_____	Type___:	_____	Swollen Ankles/Feet:	_____
Chemical		Herpes:	_____	Swollen Neck Glands:	_____
Dependency:	_____	High Blood		Thyroid Problems:	_____
Chemotherapy:	_____	Pressure:	_____	Tonsillitis:	_____
Circulatory		Jaundice:	_____	Tuberculosis:	_____
Problems:	_____	Jaw Pain:	_____	Tumor:	_____
Congenital		Kidney Disease:	_____	Ulcer:	_____
Heart Lesions:	_____	Liver Disease:	_____	Venereal Disease:	_____
Cortisone		Low Blood		Weight Loss	
Treatments:	_____	Pressure:	_____	(unexplained):	_____
Cough		Mitral Valve			
(persistent):	_____	Prolapse:	_____		
Diabetes:	_____	Multiple			
Emphysema:	_____	Sclerosis:	_____		

***Have you ever been "premedicated" with antibiotics prior to receiving dental treatment, or informed that you should be premedicated?**_____

***WOMEN:** Are you pregnant? Yes___No___. Due date:_____Are you nursing? Yes___No___.
Are you taking birth control pills? Yes___No___.

***MEDICATIONS:**
List any medications you are currently taking and the diagnosis:
_____
_____
_____
_____

***ALLERGIES:** (Check all that apply)

Aspirin:	_____	Local Anesthetic:	_____
Barbiturates:	_____	Penicillin:	_____
Codeine:	_____	Sulfa:	_____
Iodine:	_____	Latex:	_____
Metals:	_____	Other:	_____

Pharmacy Name:_____Phone #:_____

FINANCIAL POLICY

As a courtesy to you, we will be happy to file your claim with your employee benefit plan.

At your request, we can offer a Pre-Treatment Estimate from your benefits plan. A Pre-Treatment Estimate does not mean, however, that your benefit plan will guarantee payment. The payment is subject to plan provisions and eligibility at the times services are actually rendered.

We accept cash, checks, Visa and MasterCard. We also offer third-party, no interest financing through Care Credit.

Also as a courtesy, we will try to provide you with estimates **(not quotes)** for your dental work. The benefits estimated are not guaranteed. If for any reason your insurance does not pay for your dental work, it is your responsibility to pay the remaining balance on your account regardless of any estimates we may have provided.

Payment Options:
-Hygiene and all other minor visits: we will ask for your portion on the date of service
-Crowns, Bridges, Dentures, Implants: ***a 50% deposit is required at the 1st appointment and the remaining balance will be due on or before the seat date/final appointment***

Cancellation Policy:
We reserve your appointment time exclusively for you. Should you find it necessary to make a change to your scheduled appointment, we request you call our office during business hours at least 2 business days (Monday-Thursday) prior to your appointment. This allows us to contact other patients in need of care who would like a sooner appointment. There is a minimum charge of $75 for appointments broken without 2 business days notice.

I have reviewed the payment/cancellation policy above and agree to the terms.

_____

Signature *Date*

_____

Print Name

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

MALINDA LAM-GERSHONY, DDS
16710 NE 79th ST-Suite 100
Redmond, WA 98052
425.867.1484

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). 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. 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(if not self):_____

I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below (please circle):

Any Immediate Family: Yes No **Any Extended Family:** Yes No **Other:** _____