Harbor View

DENTISTRY

First Name:_____ Preferred Name:_____Last Name:_____

Birthdate _____/_____/ _____ Social Security No_____

Phone: Home _____ Work _____Cell_____

Email: _____

Referred to us by: _____

Home Address _____ City _____ ST_____ZipCode:_____

Billing Address _____City_____ST_____Zip Code:_____

Emergency contact name: _____ Phone number: _____

DENTAL INSURANCE

Company Name _____

Name _____SS#_____

Employer _____

Group # _____ Birthdate _____

SECONDARY INSURANCE

Company Name_____

Name_____SS# _____

Employer _____

Group # _____Birthdate _____

Name of your medical doctor: _____ Date of last visit to medical doctor: _____

Name of previous dentist: _____ Date of last visit to dentist: _____

DENTAL HEALTH HISTORY

	Y	N
Are you apprehensive about dental treatment? _____	☐	☐
Have you had problems with previous dental treatment?	☐	☐
Do you gag easily? _____	☐	☐
Do you wear dentures? _____	☐	☐
Does food catch between your teeth? _____	☐	☐
Do you have difficulty in chewing your food? _____	☐	☐
Do you chew on only one side of your mouth? _____	☐	☐
Do you avoid brushing any part of your mouth because of pain? _____	☐	☐
Do your gums bleed easily? _____	☐	☐
Do your gums bleed when you floss? _____	☐	☐
Do your gums feel swollen or tender? _____	☐	☐
Have you ever noticed slow-healing sores in or about your mouth? _____	☐	☐
Are your teeth sensitive? _____	☐	☐
Do you feel twinges of pain when your teeth come in contact with:		
Hot foods or liquids? _____	☐	☐
Cold foods or liquids? _____	☐	☐
Sours? _____	☐	☐
Sweets? _____	☐	☐
Do you take fluoride supplements? _____	☐	☐
Are you dissatisfied with the appearance of your teeth?	☐	☐
How often do you brush? _____		
How often do you floss? _____		

	Y	N
Does your jaw make noise so that it bothers you or others? _____	☐	☐
Do you clench or grind your jaws frequently? _____	☐	☐
Do your jaws ever feel tired? _____	☐	☐
Does your jaw get stuck so that you can't open freely? __	☐	☐
Does it hurt when you chew or open wide to take a bite?	☐	☐
Do you have earaches or pain in front of the ears? _____	☐	☐
Do you have any jaw symptoms or headaches upon awaking in the morning? _____	☐	☐
Does jaw pain or discomfort affect your appetite, sleep, daily routine, or other activities? _____	☐	☐
Do you find jaw pain or discomfort extremely frustrating or depressing? _____	☐	☐
Do you take medications or pills for pain or discomfort (Pain relievers, muscle relaxants, antidepressants)? _	☐	☐
Do you have a temporomandibular (jaw) disorder (TMD)? _____	☐	☐
Do you have pain in the face, cheeks, jaws, joints throat or temples? _____	☐	☐
Are you unable to open your mouth as far as you want?		
Are you aware of an uncomfortable bite? _____	☐	☐
Have you had a blow to the jaw (trauma)? _____	☐	☐
Are you a habitual gum chewer or pipe smoker? _____	☐	☐

MEDICAL HEALTH HISTORY

Do you have, or have you had, any of the following

	Y	N
Heart Problems _____		
Chest pain _____		
Shortness of breath _____		
Blood pressure problem _____		
Heart murmur _____		
Heart valve problem _____		
Taking heart medication _____		
Rheumatic fever _____		
Pacemaker _____		
Artificial heart valve _____		
Nitroglycerin tabs _____		
Blood Problems _____		
Easy bruising _____		
Frequent nosebleeds _____		
Allergy Problems _____		
Sinus problems _____		
Taking allergy medication _____		
Asthma _____		
Other allergies: _____		
Intestinal Problems _____		
Kidney problems _____		
Bone or Joint Problems _____		
Back or neck pain _____		
Fainting Spells, Seizures, or Epilepsy _____		
Stroke(s) _____		
Frequent or severe headaches _____		
Premedication required by physician _____		
Cancer/ Tumor_____		

	Y	N
Diabetes _____		
Urinate more than 6 times a day _____		
Thirsty or mouth is dry much of the time _____		
Family history of diabetes _____		
Tuberculosis or other respiratory disease _____		
Do you smoke? _____		
If so, how much? _____		
Hepatitis, Jaundice, or liver trouble _____		
Herpes or other STD _____		
HIV-positive/AIDS _____		
Glaucoma _____		
Do you wear contact lenses _____		
History of head injury _____		
Epilepsy or other neurological disease _____		
Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____		
If so, please describe: _____		

Are you allergic, or have you reacted adversely to any of the following?	**Y**	**N**
Local anesthetics ("Novocaine") _____		
Penicillin or other antibiotics _____		
Sulfa drugs _____		
Barbiturates, sedatives, or sleeping pills_____		
Aspirin, Acetaminophen, or Ibuprofen _____		
Codeine, Demerol, or other narcotics _____		
Reaction to metals _____		
Latex or rubber dam _____		
Other:_____		

During the past 12 months, have you taken any of the following?	**Y**	**N**
Antibiotics or sulfa drugs _____		
Anticoagulants (e.g., Coumadin) _____		
High blood pressure medicine _____		
Aspirin _____		
Digitalis or drugs for heart trouble _____		
Nitroglycerin _____		
Cortisone (steroids) _____		
Other: _____		

Women	**Y**	**N**
Are you taking contraceptives or other hormones? _____		
Are you pregnant? _____		
If so, expected delivery date _____		
Are you nursing? _____		

PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING

_____

_____

_____

_____

_____

Patient/Parent Signature **Date**

Acknowledgement Of Privacy Practices

Harbor View Dentistry

Jim Aichlmayr, DMD - Gig Harbor, WA

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 below 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 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 barrier
- Emergency situation
- Other

Notice of Privacy Practices
Harbor View Dentistry
Jim Aichlymayr, DMD

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 WITHOUT SPECIFIC WRITTEN AUTHORIZATION

We may use and disclose your health information for different purposes, including treatment, payment, and health care operations. ALL legitimate and responsible. 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 and others involved in the continuation of your healthcare/medical care.

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 / medical 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. We may also contact you regarding your healthcare/medical care, via specified phone or cell phone, work phone, texting, faxing, post card reminder,
e mail or traditional, by way of US Post Office or any other authorized courier.

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 involved in the continuation of your healthcare/dental/medical care, regarding specific care, treatment or payment. 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:

- Prevent or control disease, injury or disability;
- Report child abuse or neglect;
- Report reactions to medications or problems with products or devices;
- Notify a person of a recall, repair, or replacement of products or devices;
- Notify a person who may have been exposed to a disease or condition; or
- 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.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process instituted by someone else involved in the dispute, but only if efforts have been made, either by the requesting party or us, to tell you about the request or to obtain an order protecting the information requested.

Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information.

Coroners, Medical Examiners, and Funeral Directors. We may release your PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose PHI to funeral directors consistent with applicable law to enable them to carry out their duties.

Fundraising. We may contact you to provide you with information about our sponsored activities, including fundraising programs, as permitted by applicable law. If you do not wish to receive such information from us, you may opt out of receiving the communications.

Other Uses and Disclosures of PHI

Your authorization is required, with a few exceptions, for disclosure of psychotherapy notes, use or disclosure of PHI for marketing, and for the sale of PHI. We will also obtain your written authorization before using or disclosing your PHI for purposes other than those provided for in this Notice (or as otherwise permitted or required by law). You may revoke an authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your PHI, except to the extent that we have already taken action in reliance on the authorization.

Your Health Information Rights

Access. You have the right to look at or get copies of your health information, with limited exceptions. You must make the request in writing. You may obtain a form to request access by

using the contact information listed at the end of this Notice. You may also request access by sending us a letter to the address at the end of this Notice. If you request information that we maintain on paper, we may provide photocopies. If you request information that we maintain electronically, you have the right to an electronic copy. We will use the form and format you request if readily producible. We will charge you a reasonable cost-based fee for the cost of supplies and labor of copying, and for postage if you want copies mailed to you. Contact us using the information listed at the end of this Notice for an explanation of our fee structure.

If you are denied a request for access, you have the right to have the denial reviewed in accordance with the requirements of applicable law.

Disclosure Accounting. With the exception of certain disclosures, you have the right to receive an accounting of disclosures of your health information in accordance with applicable laws and regulations. To request an accounting of disclosures of your health information, you must submit your request in writing to the Privacy Official. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to the additional requests.

Right to Request a Restriction. You have the right to request additional restrictions on our use or disclosure of your PHI by submitting a written request to the Privacy Official. Your written request must include (1) what information you want to limit, (2) whether you want to limit our use, disclosure or both, and (3) to whom you want the limits to apply. We are not required to agree to your request except in the case where the disclosure is to a health plan for purposes of carrying out payment or health care operations, and the information pertains solely to a health care item or service for which you, or a person on your behalf (other than the health plan), has paid our practice in full.

Alternative Communication. You have the right to request that we communicate with you about your health information by alternative means or at alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. We will accommodate all reasonable requests. However, if we are unable to contact you using the ways or locations you have requested we may contact you using the information we have.

Amendment. You have the right to request that we amend your health information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances. If we agree to your request, we will amend your record(s) and notify you of such. If we deny your request for an amendment, we will provide you with a written explanation of why we denied it and explain your rights.

Right to Notification of a Breach. You will receive notifications of breaches of your unsecured protected health information as required by law.

Electronic Notice. You may receive a paper copy of this Notice upon request, even if you have agreed to receive this Notice electronically on our Web site or by electronic mail (e-mail).

Questions and Complaints

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or if you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Please Contact:
Jim Aichlmayr, DMD
3220 Uddenberg Ln #6
Gig Harbor, WA 98335
253-858-2560

If we cannot resolve your complaint you have the right to file a complaint with the Secretary of the department of Health & Human Services (HHS) Office for Civil Rights, 2201 6th Avenue, MS RX-11, Seattle, WA 98121-1831. The quality of your care will not be jeopardized nor will You be penalized for filing a complaint.

Harbor View Dentistry
Dr. James L Aichlmayr
3220 Uddenberg Lane, Suite 6
Gig Harbor, WA 98335

Financial Agreement

It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Payment of estimated patient portion is due at the time of treatment. We desire to make dental treatment affordable to all of our patients. Therefore we offer the following payment options:

1. Flexible payment plans of up to 6 months upon approval with Care Credit. Approval must be received prior to treatment date.

2. Cash, Check, Visa, MasterCard, American Express, or Discover

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. All charges will be paid in full within 90 days from start of treatment. I am aware past due accounts will be subject to a charge of 1.5% per month interest. I am responsible for all collection costs incurred by the dental office and there is a $30.00 fee on a returned check.

Missed Appointments or No Show
For our office, a missed dental appointment prevents us from scheduling another patient that could benefit from treatment. We schedule individual time with each patient to allow us to deliver the quality, personal care that every patient deserves.

Cancellations or failed appointments made with less than two business days' notice will be subject to a $100 **per hour**. If a true emergency should arise the policy will be re-evaluated on a case by case basis.

Patient name_____

Signature of Patient and or Legal Guardian_____ Date_____