Patient Registration

Please provide **ALL** requested information.

Patient Information

Last Name: ______________________________
First Name: ______________________________
Middle Name: ______________________________
Birth Date: ____________________ Age: __________
SSN: ______________________________
Sex: __________ Marital Status: ____________________
Name you wish to be called: ____________________
Student: Y / N FT / PT
Double Insurance Coverage: Y / N
Person Responsible for Account: ____________________

Address: ______________________________
City/State: ______________________________
Zip Code: ______________________________
Home Phone: ______________________________
Cell Phone: ______________________________
Email: ______________________________
Occupation: ______________________________
Referred By: ______________________________

Best way to Contact: cell / home / work / email / text

Primary Insurance Policy Holder

Last Name: ______________________________
First Name: ______________________________
Middle Name: ______________________________
SSN: ______________________________
Birth Date: ______________________________
Address: ______________________________
City/State: ______________________________
Zip Code: ______________________________
Home Phone: ______________________________
Relation to Patient: ______________________________

Employer: ______________________________
Business Address: ______________________________
City/State: ______________________________
Zip Code: ______________________________
Work Phone: ______________________________
Insurance Company: ______________________________
Insurance Phone: ______________________________
Membership ID#: ______________________________
Group #: ______________________________

Secondary Insurance Policy Holder

Last Name: ______________________________
First Name: ______________________________
Middle Name: ______________________________
SSN: ______________________________
Birth Date: ______________________________
Address: ______________________________
City/State: ______________________________
Zip Code: ______________________________
Home Phone: ______________________________
Relation to Patient: ______________________________

Employer: ______________________________
Business Address: ______________________________
City/State: ______________________________
Zip Code: ______________________________
Work Phone: ______________________________
Insurance Company: ______________________________
Insurance Phone: ______________________________
Membership ID#: ______________________________
Group #: ______________________________

Emergency Information

Name of contact for emergency (not living in the same household): ______________________________
Phone: ______________________________ Relationship: ______________________________

Signature: ______________________________ Date: ______________________________

Revised Feb 2012

Medical and Dental History

Name: ____________________
Date of Birth: ____________ Sex: Male / Female
Height: ____________ Weight: ____________

Name of Physician, City, and Phone Number: ____________________
My last physical exam was on: Month: ____________ Year: ____________

1. Are you now under the care of a physician? Yes / No
   If yes, for what condition? ____________________
2. Have you been hospitalized for an illness or surgery in the past 5 years? Yes / No
   If yes, please list the reasons and dates: ____________________
3. Are you currently taking any medication? (Including non-prescription) Yes / No
   If yes, please list: ____________________
4. Have you ever had an allergic reaction to any medication? Yes / No
   If yes, please list medication and reaction: ____________________
5. Have you ever had an adverse reaction to dental anesthetic? Yes / No
   If yes, please describe: ____________________
6. Have you ever had an allergic reaction to metal? Yes / No
7. Do you currently smoke? Yes / No
   If yes, please specify what and how much: ____________________

Circle any of the following which you have had or have at present:

Heart Trouble/Heart Attack
Heart Problems*
Artificial Limb or Joint*
Any Type of Transplant/Implant*
Thyroid Disease
Epilepsy, Seizures or Fainting
Mental Health Disorder
Sleep Disorder, Snoring
Sexually Transmitted Disease
Cancer, Tumor, Chemotherapy Or Radiation Treatment

Immune Deficiency Syndrome (AIDS, HIV, ARC)
Liver Disease (Hepatitis, Jaundice)
Respiratory Disorder (Asthma, Emphysema, Tuberculosis)
Blood Disorder (Anemia, Abnormal Bleeding)
Allergy, Hives or Skin Rash (Latex, Iodine)
Osteoporosis, Medications (Fosamax, Boniva)

Ulcer, Reflux
Kidney Trouble
Substance Abuse
High Blood Pressure
Arthritis
Diabetes
Pacemaker
Eating Disorder
Prosthetic Heart Valve
Chest Pain/ Angina
Stroke

**Antibiotic premedication may be required prior to your appointment*

Women: Are you pregnant or trying to become pregnant? Yes / No
Are you aware of any other medical condition not listed above that we should know about? Yes / No
If yes, please describe: ____________________

If you could change something about your smile, what would it be? ____________________

Circle any of the following which you have had or have at present:

Orthodontics (Braces)
Wisdom Teeth Extractions
Oral or Facial Surgery
Injury to Face or Jaw

Sores on Lips or in Mouth
Gum Disease/Bleeding Gums
Sensitive Teeth (Hot, Cold, Sweets)
TMJ Problems (Trouble Chewing)

Root Canal Treatment
Dry Mouth
Partials/Dentures
Chronic Headaches

If the above information is correct to the best of your knowledge, please sign below:

Patient Signature: ____________________ Date: ____________

1002 Park Ave. North, Suite K
Renton, WA 98057
P: 425.226.1990
F: 425.228.6806
www.gofamilydentistry.com
info@gofamilydentistry.com

Office Financial Policies

We are committed to providing you with high quality dental care. We have found that a clear understanding of our office financial policies greatly relieves some of the anxiety associated with going to a dental office.

Cash and Personal Checks – Always welcome. This entitles you to a 5% discount if paid in full at time of service. Seniors 65 years or older will receive another 5% discount (neither discount applies if you have insurance coverage).

Debit/Credit Cards – We accept Visa, MasterCard, American Express, Discover and debit cards.

Payment Plans – Available through CareCredit, 12 month no-interest financing upon approval of credit application (for treatment over $1,000).

Insurance – Co-payments will be **ESTIMATED** and **DUE** at time of service. As a courtesy to our patients, we will submit all necessary information and bill to your insurance company. **You are ultimately responsible for your bill, regardless of insurance coverage.** Please take the time to understand your policy.

Emergencies – New patients will be seen on a cash basis unless insurance coverage can be verified.

Cancelled Checks – There is a $35 fee for all returned checks.

Service Charges – All service charges are due to be paid within ninety (90) days, regardless of whether or not any insurance benefits have been received from your insurance company. Accounts over 90 days from date of service are subject to 1.5% interest per month. Therefore, we strongly advise that you follow up with your insurance company to expedite the payment process.

Cancellations and No-Shows – Please provide two (2) business days' notice if you are unable to keep your appointment. **There is a fee charged for same day cancellation and each no-show.** Failure to contact us or late arrival for scheduled appointments may result in the loss of privilege to schedule future appointments in our office. (These fees are subject to change.)

Collections – Any fees incurred as a result of turning a delinquent account to collections will be the responsibility of the account holder.

I have reviewed the above and hereby acknowledge that I understand the office financial policies.

Print Name ____

Signature ____ Date: ____________________

NOTICE OF PRIVACY PRACTICES

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principal concept of our practice. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the State of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given to anyone – even family members – without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our office and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality of your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health practice operations, and comply with the law. This may include your name, address, telephone number(s), Social Security Number, employment data, medical history, health records, etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, your personal information will always be protected to the full extent of the law.

Disclosure of Your Protected Health Information

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Rule. You have a right to and will be provided all information relating to any breach involving your personal protected health information.

Your Rights as Our Patient

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

We thank you for being a patient at our office. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.

Revised Feb 2012

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have received a copy of the Notice of Privacy Practices for the office of Daniel Y. Go, DDS, PS. This form describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office's health care operations.

Daniel Y. Go, DDS, PS reserves the right to make any necessary revisions described in the Notice of Privacy Practices. If privacy practices change, I will be offered a revised copy of the Notice of Privacy Practices when the changes become effective.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Notice of Privacy Practices, I hereby authorize disclosure of my protected health care information to the persons indicated below.

Any member of my immediate family: ______________________________ Y / N
Spouse: ____ Y / N
Other (please specify): _______________________________________ Y / N

______________________________	______________________________
Name of Patient or Patient's Guardian	Signature of Patient or Patient's Guardian
______________________________	______________________________
Date	Guardian Relationship to Patient