HENRY HAN CHIN D.D.S., P.L.L.C

901 19TH AVENUE EAST
SEATTLE, WA 98112
(206) 621-1233

Medical and Dental History

Date: _____

Patient Name: First_____ MI____ Last_____ Nickname _____

Social Security Number:_____ **DOB:**_____

Address: Street_____
City_____ State_____ Zip_____

Phone: Mobile_____ Work_____ Home_____

Email: _____
I agree to receive by email Appointment Reminders □ Practice Newsletter □

What is your preferred method of contact? Home Phone □ Work Phone □ Mobile Phone □ Email □

Patient Employed By_____ **Occupation**_____

MINOR INFORMATION RELEASE:

Is the patient a minor? Yes □ No □

Name of Responsible Party: First_____ Last_____

DOB:_____ **Relationship to Patient:** Self □ Parent □ Other □

Address *(if different from above)* Street_____
City_____ State_____ Zip_____

Phone: Mobile_____ Work_____ Home_____

DENTAL BENEFIT PLAN INFORMATION:

Primary Dental Plan Name _____ **Phone**_____

Address Street_____
City_____ State_____ Zip_____

Name of subscriber _____ **DOB**_____ **ID/SSN #**_____

Group Name _____ **Group #**_____

Secondary Dental Plan Name _____ **Phone**_____

Address Street_____
City_____ State_____ Zip_____

Name of subscriber _____ **DOB**_____ **ID/SSN #**_____

Group Name _____ **Group #**_____

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Patient Name:_____DOB:_____

What is your immediate dental concern? _____

PLEASE FILL OUT ALL THAT APPLY TO YOU:

1. Are you fearful of dental treatment? How fearful, on a scale of 1 (Least) to 10 (Most)

_____

2. Have you ever taken medication to cope with dental anxiety?

_____

3. Have you had an unfavorable dental experience. If so, please explain.

_____

4. Have you ever had trouble getting numb or had any reactions to local anesthetic?

_____

5. Do you have problems with your jaw joint? (Pain, sounds, limited opening, locking or popping)

_____

6. Do you clench your teeth or do they feel sore during the day?

_____

7. Do you have any problems with waking up with a headache or an awareness of your teeth during sleep?

_____

8. Do your gums bleed or are they painful when brushing or flossing?

_____

9. Have you ever been treated for gum disease or been told you have lost bone around your teeth?

_____

10. Are any teeth sensitive to hot, cold, biting, sweets or do you avoid brushing any part of your mouth?

_____

11. Is there anything about the appearance of your teeth that you would like to change?

_____

12. Have you ever whitened (bleached) your teeth?

_____

13. Have you been disappointed with the appearance of previous dental work?

_____

SIGNATURE:_____ DATE:_____

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Patient Name:_____

Name of Primary Physician (PCP): _____

Address: _____Phone Number:_____

PLEASE CHECK ALL THAT APPLY TO YOU:

Abnormal Bleeding	☐	Diabetes	☐	Kidney Problems/disease	☐
Alcohol/Drug Abuse	☐	Difficulty Breathing	☐	Liver Disease	☐
Allergies	☐	Epilepsy/Seizures	☐	Mitral Valve Prolapse	☐
Angina Pectoris	☐	Fainting Spells	☐	Pace Maker	☐
Arthritis	☐	Headaches/Fatigue	☐	Pain in Jaw Joints	☐
Artificial Bones/Joints	☐	GERD/Acid Reflux	☐	Psychiatric Problems	☐
Artificial Heart Valve	☐	Glaucoma	☐	Radiation Therapy	☐
Asthma	☐	HIV/AIDS/STD	☐	Rheumatic Fever	☐
Autoimmune Disease	☐	Hay Fever	☐	Sinus Problems	☐
Blood Clotting Conditions	☐	Heart Attack	☐	Stroke	☐
Cancer/Chemotherapy	☐	Heart Surgery	☐	Thyroid Problems	☐
Congenital Heart Defect	☐	Hepatitis A, B, or C	☐	Tuberculosis	☐
Dental Anxiety	☐	High Blood Pressure	☐	Venereal Disease	☐

☐ Other, please specify:_____

☐ Hospitalized/Major Surgery:_____

ALLERGIES (Please Check All that Apply)

Aspirin	☐	Latex	☐
Codeine	☐	Penicillin (Or Derivative)	☐
Dental Anesthetics	☐	Sulfa	☐
Erythromycin	☐	Tetracycline	☐
Jewelry/Metals	☐	Fluoride	☐

Other_____

Do you smoke or chew tobacco? Yes ☐ No ☐

If yes, # of years _____

IF FEMALE ARE YOU:

☐ Taking Birth Control?

☐ Pregnant? If so, # of weeks:_____

Please list any medications you are currently taking:

_____

_____

_____

_____

_____

_____

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATION YOU MAY BE TAKING.

SIGNATURE:_____ **DATE:**_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Our office operates on a "fee-for-service" basis. That means that payment is expected at the time of service. **If you have insurance, your estimated portion is due at the time of service.** Upon receipt of the insurance payment, we will reconcile the account, and bill or refund any difference. For your convenience we accept cash, check, Visa, MasterCard, American Express & Discover. For extensive treatment needs, we offer an extended payment plan through Care Credit. **Initial ____**

All fees for treatment will be discussed at the initial consultation. Should additional unforeseen problems arise as treatment progresses, this estimate may have to be revised. You will be consulted before any unexpected treatment is undertaken. If and when such changes in treatment do occur, please request an updated estimate from the administrative staff. We accept cash, personal check, MasterCard and Visa. There will be a $25.00 handling fee for any returned checks. On balances over 90 days from the date of service, there is a fee of 1% monthly interest charge (12% annually). **Initial____**

Please familiarize yourself with your insurance plan & provisions, and provide us with accurate and up-to-date information as necessary. As a courtesy, we will submit claims to your dental insurance company on your behalf. We will accept payments directly from your insurance company provided payment is received from them within 60 days. If Payment has not been received within 60 days, we may ask that you provide assistance in dealing with your insurance company. Please remember your benefits are a contract between you (and possibly your employer) and your insurance company; therefore, you are ultimately responsible for the total amount of your dental fees. Further, Dr. Henry Chin makes treatment recommendations regardless of your dental benefits, deductibles, limitations or maximums. **Initial____**

Short notice cancellations (those appointments cancelled without **2 BUSINESS DAYS prior notice**) and “no shows” are extremely costly to our practice and are unfair to those patients in need of care who may have otherwise appreciated an earlier appointment. **For these reasons we reserve the right to assign a broken appointment fee of $75. Initial____**

In order to customize any conversation regarding proposed dental treatment, please choose which of the following best suits your needs:

___ **Tell me everything:** Provide me with information about my entire dental health condition and inform me of all options available

___ **Insurance only:** I only wish to hear about treatment that may be covered under my calendar year maximum. I Understand my insurance will likely have a co-payment which I am responsible for. Further, I understand there may me medical/dental health risks involved should I choose to address on those things covered by my insurance.

___**Minimal cost:** Focus only minimizing all costs and inform me of only the highest priority in treatment. I understand there may be medical and dental health risks involved if I should choose to address only the highest priority procedures for my dental care.

My signature verifies that I understand the policies as outlines above, and any questions I have with regard to these policies have been answered. Please remember you are fully responsible for all fees charged by this office regardless of your insurance coverage.

Patient or Responsible Party Signature_____ Date_____
Patient Name (please print)_____

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Notice of Privacy Practices

FEDERAL REQUIREMENT FOR ALL PATIENTS
PLEASE READ AND FILL OUT FIELDS BELOW

All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information (PHI) is practiced.

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, such as insurance companies, 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 the Acknowledgement Form 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 (Printed)	
Patient Signature (Parent/Guardian Signature if Patient Under 18)	**Date:**
Please list the names of ANY person other than yourself that may be granted access to your account or treatment information:	

If we are unable to reach you, Is it okay to:

Yes □ No □ Leave a detailed voice message
Yes □ No □ Permission to contact via E-mail & Text Messaging

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because (check one):

□ Individual refused to sign

□ Communications barriers prohibited obtaining the acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement

□ Other (Please Specify) _____