SNOQUALMIE RIDGE FAMILY DENTAL

Patient Information

Thank you for choosing Snoqualmie Ridge Family Dental for your oral health care needs.
In order to better serve you, please answer the following questions. Your personal and protected health information (PHI) are confidential and protected under the Health Insurance Portability and Accountability Act (HIPAA). Please let us know if you have any questions or concerns.

For existing patient: ☐ **No changes** **Initial:** _____ **Date:** _____

Patient name: _____ Date of birth: _____

Social security number: _____ Gender: ☐ Female ☐ Male ☐ Other/Pronoun: _____

Family status: ☐ Single ☐ Married

Cell phone: _____ Address: _____

Home phone: _____ _____

Email: _____

Preferred method of communication: ☐ Phone ☐ Text message ☐ Email

Emergency contact: _____ Phone number: _____ Relationship: _____

Who may we thank for referring you or how did you find us?

☐ Google ☐ Facebook ☐ Yelp ☐ Other: _____

Dental Benefits/Insurance Plan

You can skip this section if you have provided your dental benefits/insurance information or if you do not have a dental benefits/insurance plan.

Subscriber name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent/guardian ☐ Other: _____

Subscriber's birthday (if not "self"): _____ Subscriber's phone number (if different): _____

Subscriber's address (if different): _____

Subscriber's employer: _____ Dental benefits/insurance company name: _____

Subscriber ID: _____ Group #: _____

Secondary Dental Benefits/Insurance Plan (if applicable)

Subscriber name: _____

Relationship to patient: ☐ Self ☐ Spouse ☐ Parent/guardian ☐ Other: _____

Subscriber's birthday (if not "self"): _____ Subscriber's phone number (if different): _____

Subscriber's address (if different): _____

Subscriber's employer: _____ Dental benefits/insurance company name: _____

Subscriber ID: _____ Group #: _____

Regarding Insurance:

We will assist you with billing your dental insurance company. Please provide our office with the accurate insurance and plan information. We encourage you to familiarize yourself with your insurance benefits and its limitations. Insurance is a contract between you and the insurance company, and our office is only a third party to that contract. We encourage you to contact your insurance company if you have questions about your plan.

All co-insurances and deductibles are due at the time of appointment, unless otherwise arranged with the our office.

We will do our best to accurately determine treatment and associated co-insurances before beginning treatment. While we try to make the treatment estimates as accurate as possible, there may be instances where discrepancies do occur. We will inform you of any changes to your treatment as they arise. The balance is your responsibility whether your insurance company pays or not.

Authorization and Release

- 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 payers, insurance companies, and/or other health and dental practitioners.
- I authorize and request my insurance company, if any; to pay directly to your office the insurance benefits otherwise payable to me. Your office is providing a courtesy to me by allowing me to assign my insurance benefits to your dental office, your office may terminate this courtesy at any time.
- I understand that my dental insurance company and/or my 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 the behalf of my dependents, should my insurance company and/or my responsible party fail to pay or pay less than full for such services for any reasons.
- I understand that my estimated co-insurance is due in full at the time of treatment

X _____ _____

Signature of patient (or parent/guardian if minor) Date

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my protected health information. I understand that this information can be and will be used to:

1.) Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

2.) Obtain payment from third-party payers.

3.) Conduct normal healthcare operations.

I acknowledge that I have access to your Notice of Privacy Practices containing a more complete description of the uses and disclosure of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time 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 operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I authorize your office to share my information with my ☐ Spouse ☐ Caretaker ☐ Other: _____

Patient Name_____ Signature_____

Signature of patient (or parent/guardian if minor)