

***Welcome to our office***  
**Cooleysmiles**  
**Patient Registration Form**

MR MRS MS	FIRSTNAME	M.I.	LASTNAME	PREFERRED NAME	MARTAL STATUS	SOCIAL SECURITY NUMBER
HOME ADDRESS				MAILING ADDRESS IF DIFFERENT		
CITY	STATE	ZIP	HOME PHONE	WORK PHONE	CELL PHONE	
PERSON RESPONSIBLE FOR ACCOUNT						
ADDRESS(CITY, STATE, ZIP)						
HOME PHONE		WORK PHONE		EXT	BIRTHDATE	
EMPLOYER		EMPLOYER PHONE #		SOCIAL SECURITY NUMBER		
RELATION TO PATIENT				DRIVER'S LICENSE #		
<b>INSURANCE INFORMATION:-PLEASE PROVIDE THE FOLLOWING INFORMATION AND A PHOTO COPY OF YOUR INSURANCE CARD(S)</b> <i>(front &amp; back)</i>						
SUBSCRIBER'S NAME			INSURANCE COMPANY			
EMPLOYER		INSURANCE COMPANY ADDRESS			INSURANCE PHONE NUMBER	
GROUP #	ID#	SUBSCRIBERS BIRTHDATE		SUBSCRIBERS SS#		
SUBSCRIBER'S NAME			INSURANCE COMPANY			
EMPLOYER		INSURANCE COMPANY ADDRESS			INSURANCE PHONE NUMBER	
GROUP #	ID#	SUBSCRIBERS BIRTHDATE		SUBSCRIBERS SS#		
<b>EMERGENCY CONTACT INFORMATION</b>						
NAME		PHONE		RELATIONSHIP		
ADDRESS						

**Whom may we thank for referring you?** \_\_\_\_\_

**RELEASE OF INFORMATION**

I herby authorize release of any information, including the diagnosis and records of treatment or examinations rendered to my insurance company or companies. I herby authorize payment directly to the dentist the group insurance benefits otherwise payable to me. I understand that responsibility for payment on dental services provided in this office for myself or dependents is mine. All outstanding balances over 90 days shall accrue interest at the rate of 1.5% per month.

Signed \_\_\_\_\_  
 Patient, Parent or Guardian Signature

# Cooley Smiles

## ***Why a privacy policy now?***

It is our desire to communicate to you that we are taking the new Federal (Hippa) Health Insurance Portability and Accountability Act laws written to protect the confidentiality of your health information seriously. The changes in the evolution of computer technology and its use in healthcare have prompted the government to seek a way to standardize and protect the privacy of the electronic exchange of your health information. Cooley Smiles respects your privacy; we understand that your personal health information is very sensitive. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do. The law protects the privacy of the health information we create and obtain in providing our care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

## ***Notice of Privacy Practices***

This notice describes how medical information about you may be used and disclosed, and how you can get access to this information. Please read carefully.

Examples of Use and Disclosure of Protected Health Information of Treatment, Payment and Health Operations.

### ***For Treatment:***

Information obtained by a dentist, dental hygienist, dental assistant or member of our health care team will be recorded in your dental record and used to help decide what care may be right for you. We may also provide information to others providing your care. This will help them stay informed about your care.

### ***For Payment:***

- We request payment from your health insurance plan. Health plans need information from us about your dental care. Information provided to health plans may include your diagnoses, procedures performed, or recommended care.

### ***For Health Care Operations:***

- We use your dental records to assess quality and improve service.
- We may use and disclose dental records to review the qualifications and performance of our health care providers and to train our staff.
- We may contact by phone, letter, post card or email to remind you about appointments and give you information about treatment alternatives or other health-related benefits and services.
- We may use and disclose information to conduct or arrange services, including:
  - ◊ Dental quality review by you health plan;
  - ◊ Accounting, legal, risk management and insurance services.
  - ◊ Audit functions, including fraud and abuse detection and compliance programs

## ***Your Health Information Rights***

The health and billing records we create and store are the property of Cooley Smiles. The protected health information in it, however, generally belongs to you. You have a right to:

- Receive, read and ask questions about this notice:
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us. We are not required to grant the request. But we will comply with any request granted.
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information (“Notice”);
- Request that you be allowed to see and get a copy of your protected health information. You may make this request in writing. We have a form available for this type of request.
- Have us review a denial of access to your health information-except in certain circumstances;
- Ask us to change your health information. You may give us this request in writing.
- You may write a statement of disagreement if your request is denied. It will be stored in your dental record, and included with any release of your records.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payors. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date and give us your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation. Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

## ***Our Responsibilities***

### ***We are required to:***

- Keep your protected health information private.
- Give you this notice.
- Follow the terms of this Notice.

### ***To Ask for Help or Complain:***

If you have any question, want more information, or want to report a problem about the handling of your protected health information, you may contact:

Cooley Smiles-Office Manager  
425-747-7000

If you believe your privacy rights have been violated, you may discuss your concerns with any staff member. You may also deliver a written complaint to the Office Manager at our office. You may also file a complaint with the U.S. Secretary of Health and Human Services. If you complain, we will not retaliate against you.

Other Disclosures and Uses of Protected Health Information  
For health care operations:

### ***Notification of Family and Others***

- Unless you object, we may release health information about you to a friend or family member who is involved in your dental care. We may tell your family or friends your condition and that you are in a hospital. In addition, we may disclose health information about you to assist in disaster relief.

You have the right to object to this use, or disclosure of your information. If you object, we will not disclose it.

We may use and disclose your protected health information without your authorization as follows:

For Public and Safety Purposes as Allowed or Required by Law:

- To prevent or reduce a serious, immediate threat to the health or safety of a person or the public.
- To public health or legal authorities.
  - To protect public health and safety
  - To prevent or control disease, injury or disability

### ***With Medical Researchers***

- If the research has been approved and has policies to protect the privacy of your health information. We may also share information with medical researchers preparing to conduct a research project.

### ***To the Food and Drug Administration (FDA)***

- Relating problems with food, supplements and products.

### ***To Report Suspected Abuse or Neglect to public authorities.***

### ***For Law Enforcement Purposes***

- Such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.

### ***For Disaster Relief Purposes***

For example, we may share health information with the Department of Health.

### ***Other Uses and Disclosures of Protected Health Information***

Uses and disclosures not in the Notice will be made only as allowed or required by law or with your written authorization.

### ***Web Site***

We have a Web site that provides information about us. For your benefit this Notice is on the Web site at [www.cooleysmiles.com](http://www.cooleysmiles.com)

Effective Date: April 14, 2003

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First MI (Preferred Name)  
 Male  Female  Married  Single  Child  Other \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Phone(Home): \_\_\_\_\_ (Cell Phone): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_  
 E-mail: \_\_\_\_\_ Confirmation Preference: E-mail  Telephone   
 Address: \_\_\_\_\_  
Street Apartment #  
 \_\_\_\_\_  
City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for today's visit: \_\_\_\_\_

**Have you ever had any of the following? Please check those that apply:**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> AIDS/HIV+          | <input type="checkbox"/> Fainting              | <input type="checkbox"/> Mental Disorders     | <input type="checkbox"/> Tumors             |
| <input type="checkbox"/> Allergies _____    | <input type="checkbox"/> Glaucoma              | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Growths               | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Venereal Disease   |
| <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Hay Fever             | <input type="checkbox"/> <b>Pregnancy</b>     | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Artificial Joints  | <input type="checkbox"/> Head Injuries         | Due date: _____                               | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Heart Disease         | <input type="checkbox"/> Radiation Treatment  | Other Drug Allergies::                      |
| <input type="checkbox"/> Blood Disease      | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Heart Murmur          | <input type="checkbox"/> Rheumatic Fever      | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Rheumatism           |   |
| <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Sinus Problems       |   |
| <input type="checkbox"/> Epilepsy           | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Stomach Problems     |   |
| <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Stroke               |   |
|   | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Tuberculosis         |   |
|   | <input type="checkbox"/> Liver Disease         |   |   |

- Have you ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Are you currently taking any medications?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Do you use any type of tobacco product?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Do you have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail. I acknowledge that I have been informed of the Privacy Practices of Cooley Smiles.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed: Date \_\_\_\_\_ Changes  Yes  No Signature: \_\_\_\_\_

Reviewed: Date \_\_\_\_\_ Changes  Yes  No Signature: \_\_\_\_\_

Reviewed: Date \_\_\_\_\_ Changes  Yes  No Signature: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?

- |  |                                       |  |   |
|--|---------------------------------------|--|---|
| <input type="checkbox"/> Dental Office   | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Newspaper     | <input type="checkbox"/> Magazine(Name) _____ |
| <input type="checkbox"/> Work            | <input type="checkbox"/> Website      | <input type="checkbox"/> Insurance Co. | <input type="checkbox"/> Other _____          |
| <input type="checkbox"/> Another patient |                                       |  |   |
- Name of person or office referring you to our practice: \_\_\_\_\_

# Cooley Smiles

## *Dental History*

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Name: \_\_\_\_\_ Date: \_\_\_\_\_

1. Do you have any teeth causing you any pain?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

2. Have you had any serious complications during dental treatment?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

3. Have you ever worn or do you wear a night guard?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

4. Do you have trouble flossing any areas in your mouth?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

5. Would you like to change the color of your teeth?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

6. Would you like to have your silver fillings replaced?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

7. Is there anything about your smile that you would like to change?  
 Yes       No      Comments \_\_\_\_\_

\_\_\_\_\_

8. Are there any questions or concerns that you have?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Cooley Smiles  
4100 Factoria Blvd. S.E., Suite C  
Bellevue, WA 98006

## **Appointment Commitment Agreement**

We respectfully request 48 hours advance notice for canceling or rescheduling an appointment. This allows enough time to contact our patients waiting for treatment.

If you are unable to allow 48 hours notice, our policy provides that you will receive a written notice reminding you of our Appointment Commitment Agreement. If a second occurrence happens within a 12 month time period, we will ask that all future appointments be paid in full 1 week prior to a scheduled appointment.

If you should miss the prepaid appointment, there will not be a refund of prepaid funds and all future appointments will need to be paid ahead of time. We are 100% committed to our patients and respectfully request the same in return.

Signature \_\_\_\_\_ Date \_\_\_\_\_