fme family dental

Proudly serving Fife, Milton, Edgewood & neighbors

Patient Information

Name:_____ Nickname:_____ Birthdate:_____

Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Male ☐ Female

Address:_____ City/Zip:_____ Email:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Emergency Contact: Name:_____ Relationship:_____ Phone:_____

Insurance Information

Primary	**Secondary**
Insured Employee:_____	Insured Employee:_____
Social Security or ID #:_____	Social Security or ID #:_____
Employer:_____	Employer:_____
Insurance Company:_____	Insurance Company:_____
Group Plan:_____ DOB:_____	Group Plan_____ DOB:_____

Financially Responsible Party (if other than patient)

Bill To:_____ Address:_____ City/zip:_____

Relationship to Patient:_____ Home Phone:_____

Signature:

Dental History

Check Yes or No to the following questions:

Self-Conscious About Your Teeth	☐Yes ☐No
Dental Anxiety	☐Yes ☐No
Previous Unpleasant Dental Experience	☐Yes ☐No
Satisfied With Your Past Dentistry	☐Yes ☐No
Had Orthodontic Treatment, Date_____	☐Yes ☐No
Had Periodontal Treatment, Date_____	☐Yes ☐No
Cold or Hot Sensitivity	☐Yes ☐No
Sweet Sensitivity	☐Yes ☐No
Chewing Sensitivity	☐Yes ☐No
Bleeding, Tender, or Irritated Gums	☐Yes ☐No
Food catching between your teeth	☐Yes ☐No
Tired, Clicking, or Popping Jaw	☐Yes ☐No
Clenching or Grinding	☐Yes ☐No
Pain or Discomfort in Ears, Neck, Shoulders or Back	☐Yes ☐No
Difficulty Getting Numb	☐Yes ☐No

How long has it been since your last dental visit? _____

Help us determine your risk for getting cavities by answering the following questions:

How often do you brush your teeth?_____

How often Do you floss_____

Do you notice plaque build-up on your teeth between brushing?	☐Yes ☐No
Do you take medications daily or frequently?	☐Yes ☐No
Do you notice having a dry mouth?	☐Yes ☐No
Do you drink anything other than water between meals?	☐Yes ☐No
Do you snack between meals?	☐Yes ☐No
Do you have any ortho appliances present?	☐Yes ☐No
Do any of the following apply?	☐Yes ☐No

☐ Frequent tobacco use
☐ Acid Reflux
☐ Diabetes
☐ Head/Neck Radiation Therapy
☐ Other Drug Use
☐ Bulimia
☐ Sjogren's syndrome

Additional Comments: _____

Time 8:02 AM

FME Family Dental

Date 2/16/2022

Eaglesoft Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, c

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	
Do you use controlled substances?	◯ Yes ◯ No	If yes

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic

☐ Metal ☐ Latex ☐ Sulfa Drugs ☐ Local Anesthetics

Other? ☐ If yes

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

AIDS/HIV Positive ◯ Yes ◯ No	Cortisone Medicine ◯ Yes ◯ No	Hemophilia ◯ Yes ◯ No	Radiation Treatments ◯ Yes ◯ No
Alzheimer's Disease ◯ Yes ◯ No	Diabetes ◯ Yes ◯ No	Hepatitis A ◯ Yes ◯ No	Recent Weight Loss ◯ Yes ◯ No
Anaphylaxis ◯ Yes ◯ No	Drug Addiction ◯ Yes ◯ No	Hepatitis B or C ◯ Yes ◯ No	Renal Dialysis ◯ Yes ◯ No
Anemia ◯ Yes ◯ No	Easily Winded ◯ Yes ◯ No	Herpes ◯ Yes ◯ No	Rheumatic Fever ◯ Yes ◯ No
Angina ◯ Yes ◯ No	Emphysema ◯ Yes ◯ No	High Blood Pressure ◯ Yes ◯ No	Rheumatism ◯ Yes ◯ No
Arthritis/Gout ◯ Yes ◯ No	Epilepsy or Seizures ◯ Yes ◯ No	High Cholesterol ◯ Yes ◯ No	Scarlet Fever ◯ Yes ◯ No
Artificial Heart Valve ◯ Yes ◯ No	Excessive Bleeding ◯ Yes ◯ No	Hives or Rash ◯ Yes ◯ No	Shingles ◯ Yes ◯ No
Artificial Joint ◯ Yes ◯ No	Excessive Thirst ◯ Yes ◯ No	Hypoglycemia ◯ Yes ◯ No	Sickle Cell Disease ◯ Yes ◯ No
Asthma ◯ Yes ◯ No	Fainting Spells/Dizziness ◯ Yes ◯ No	Irregular Heartbeat ◯ Yes ◯ No	Sinus Trouble ◯ Yes ◯ No
Blood Disease ◯ Yes ◯ No	Frequent Cough ◯ Yes ◯ No	Kidney Problems ◯ Yes ◯ No	Spina Bifida ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No	Frequent Diarrhea ◯ Yes ◯ No	Leukemia ◯ Yes ◯ No	Stomach/Intestinal Disease ◯ Yes ◯ No
Breathing Problems ◯ Yes ◯ No	Frequent Headaches ◯ Yes ◯ No	Liver Disease ◯ Yes ◯ No	Stroke ◯ Yes ◯ No
Bruise Easily ◯ Yes ◯ No	Genital Herpes ◯ Yes ◯ No	Low Blood Pressure ◯ Yes ◯ No	Swelling of Limbs ◯ Yes ◯ No
Cancer ◯ Yes ◯ No	Glaucoma ◯ Yes ◯ No	Lung Disease ◯ Yes ◯ No	Thyroid Disease ◯ Yes ◯ No
Chemotherapy ◯ Yes ◯ No	Hay Fever ◯ Yes ◯ No	Mitral Valve Prolapse ◯ Yes ◯ No	Tonsillitis ◯ Yes ◯ No
Chest Pains ◯ Yes ◯ No	Heart Attack/Failure ◯ Yes ◯ No	Osteoporosis ◯ Yes ◯ No	Tuberculosis ◯ Yes ◯ No
Cold Sores/Fever Blisters ◯ Yes ◯ No	Heart Murmur ◯ Yes ◯ No	Pain in Jaw Joints ◯ Yes ◯ No	Tumors or Growths ◯ Yes ◯ No
Congenital Heart Disorder ◯ Yes ◯ No	Heart Pacemaker ◯ Yes ◯ No	Parathyroid Disease ◯ Yes ◯ No	Ulcers ◯ Yes ◯ No
Convulsions ◯ Yes ◯ No	Heart Trouble/Disease ◯ Yes ◯ No	Psychiatric Care ◯ Yes ◯ No	Venereal Disease ◯ Yes ◯ No
			Yellow Jaundice ◯ Yes ◯ No

Have you ever had any serious illness not listed above? ◯ Yes ◯ No If yes

Comments:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X

Date:_____

fme family dental

david y kim, DDS
6104 20th Street East
Fife, WA 98424
p: 253-922-6667
f : 253-926-2241

FINANCIAL POLICIES

The following is an outline of our financial policy. It is our intention to inform our patients as clearly and completely as possible as to our guidelines of payment for services rendered. It is our hope that openly discussing our financial policy will prevent future financial misunderstandings and allow us to concentrate on providing the highest quality dental care and service to our patients at a reasonable fee.

As a courtesy to you, we are happy to file the necessary insurance forms to see that you receive the full benefits of your coverage. However, we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask patients to be responsible directly for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. NOTE: PLEASE MONITOR YOUR BENEFITS AND ANNUAL MAXIMUM.

In order to keep our fees reasonable, **your estimated patient portion is due at the time services are rendered, unless other payment arrangements have been made with our front office staff.** Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received.

Payments can be made with cash, check, VISA or Mastercard. CareCredit Financing is an option for 6 month 0% interest on approved credit.

There is a $40 fee on all returned checks unpaid by your bank due to NSF. Delinquent accounts will be referred to collections after 90 days unless previous arrangements have been made.

Please remember that once an appointment has been made, this time is reserved specifically for you. If you need to change or cancel your appointment, we kindly request at least 48 business hours notice. NO SHOW appointments may be assessed a fee of $100 per hour scheduled.

If you have any questions or concerns feel free to contact our office at (253) 922-6667.

I understand the above financial policy and agree to adhere by the above set policies.

Signed_____ Date_____

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Appointment Policy

We will make every effort to accommodate your scheduling needs and take pride in seeing our patients in a timely manner, therefore, we ask that you arrive for your appointment on time. If you think that you will be late, please call our office as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule your appointment.

We try to contact our patients with a "courtesy" reminder of their appointment date and time a day or two prior. This is just a courtesy and does not reduce your appointment responsibilities of any scheduling changes within our required 48 hour window. Failure to comply with this policy may result in a charge for the missed or short-notice cancelled appointment in the amount of $100 per scheduled hour.

WE REQUIRE 48 HOURS NOTICE IF YOU ARE UNABLE TO KEEP YOUR SCHEDULED APPOINTMENT. When we receive advanced notice of a scheduling change we are able to fill that time slot with another patient that requires our attention. This helps us to control our overhead costs and keep our office fees reasonable.

An appointment is considered missed or broken for one or more of the following reasons:
* Arriving 15 minutes late to your scheduled appointment time
* Failure to show up for your scheduled appointment
* Rescheduling or canceling an appointment without giving at least 48 hours notice

In our continuing efforts to extend quality and affordable dental care to our valued patients, we ask that you please respect and adhere to our appointment policy.

Consent: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_____
Print Name of Patient or Responsible Party

_____
Signature of Patient or Responsible Party Date

STATEMENT OF PRIVACY PRACTICES

FME FAMILY DENTAL

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR 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 or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to 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 HEALTHCARE INFORMATION (PHI)

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 HEALTHCARE 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 or fund-raising 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 unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

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 Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

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.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

FME Family Dental

Acknowledgement of Privacy Practices

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 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 provider has the right to change the *Notice of Privacy Practices* and that I may contact this office to obtain a current copy of the *Notice of Privacy Practices.*

ADDITIONAL DISCLOSURE AUTHORIZATION:
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer if "NO". Personal Protected Information (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse/Family member/other: please list below ○ **yes** ○ **no**

Name/Relation

Name/Relation

Name/Relation

Name/Relation

Print Name of Patient *Signature* *Date*

Responsible Party *Signature* *Date*