SHORDENTAL

Welcome to our practice. In order to serve you, please complete the following confidential information. Thank you.

Contact Information

Date _____

Name _____

Preferred Name _____

Spouse / Partner's Name_____

Address _____

City _____ State_____ Zip _____

Home Phone _____

Cell Phone _____

Email _____

Birthdate_____ Age _____

Marrried ☐ Single ☐ Divorced ☐ Domestic Partner ☐

Emergency Contact _____

Emergency Phone _____

Account Information

Person responsible for account?

_____

Your:

Employer _____

Occupation _____

Dental Benefit Information

Insurance Name_____

Subscriber _____

Date of Birth _____

Employer _____

Group #_____ Id#_____

Claim Address _____

City _____ State_____ Zip _____

Spouse / Partner Information
(if you have double coverage)

Insurance Name_____

Subscriber _____

Date of Birth _____

Employer _____

Group #_____ Id#_____

Claim Address _____

City _____ State_____ Zip _____

How Did You Find Out About Our Practice

Referred by a friend or family member? ☐

Who? _____

Other _____

Internet ☐ Sign ☐ Mailer ☐ Print Ad ☐ Coupon ☐

Patient Questionnaire - Alexander Shor DMD., MSD & Kavita Shor BDS., MSD

Name _____ Date of Birth _____

Because dentistry requires the use of drugs or invasive procedures, it is important that we have certain information about your health. All information on this form is strictly CONFIDENTIAL, and cannot be released to any other person or agency without your written permission. Please answer all of the following questions:

1. What is your estimate of your general health? (circle) POOR FAIR GOOD EXCELLENT
2. Have you been hospitalized during the past two years? Yes NO Reason? _____
3. Are you currently under the care of a physician? Yes NO Reason? _____
4. Date of last physical examination? _____
5. Physician name / contact information _____ phone # _____
6. Do you have or have you had any of the following:

Cardiovascular Disorders:

Yes	No	
☐	☐	High blood pressure
☐	☐	Congenital Heart Disease
☐	☐	Rheumatic fever
☐	☐	Heart Murmur
☐	☐	Heart Pacemaker
☐	☐	Vascular graft
☐	☐	Heart or bypass surgery
☐	☐	Artificial Heart Valve
☐	☐	Heart Attack
☐	☐	Congestive Heart Failure
☐	☐	Awaken with breathing difficulty
☐	☐	Angina pectoris / chest pain
☐	☐	Swollen ankles
☐	☐	Irregular or rapid heart beats
☐	☐	Stroke

Respiratory Disorders:

Yes	No	
☐	☐	Emphysema or Asthma
☐	☐	Hay fever
☐	☐	Chronic cough or Bronchitis
☐	☐	Tuberculosis
☐	☐	Sinus problems
☐	☐	Breathing problems

Muscular-Skeletal/CNS/ Developmental Disorders:

Yes	No	
☐	☐	Frequent headaches
☐	☐	Fainting/ Loss of consciousness
☐	☐	Seizures or epilepsy
☐	☐	Visual impairment
☐	☐	Hearing impairment
☐	☐	Artificial joint if yes, surgery date
☐	☐	Arthritis or bone disease
☐	☐	Muscle disease
☐	☐	Spinal cord injury or paralysis
☐	☐	Osteoporosis
☐	☐	Autism
☐	☐	Alzheimer's disease
☐	☐	Dementia

Gastrointestinal/ Genitourinary Disorders:

Yes	No	
☐	☐	Colitis or ulcers
☐	☐	Hepatitis / Jaundice / Liver disease
☐	☐	Renal dialysis
☐	☐	Kidney transplant
☐	☐	Kidney disease
☐	☐	Syphilis, Gonorrhea, other STD
☐	☐	Herpes
☐	☐	Frequent canker sore
☐	☐	Chronic diarrhea
☐	☐	Frequent vomiting
☐	☐	Gastric reflux/ GERD

Hematologic/ Endocrine/ Immune Disorders:

Yes	No	
☐	☐	Blood transfusion
☐	☐	Anemia / Leukemia / Lymphoma
☐	☐	Hemophilia
☐	☐	Sickle cell disease
☐	☐	Blood clots or Thrombosis
☐	☐	Diabetes if yes type:
☐	☐	Thyroid disease
☐	☐	Adrenal gland disease
☐	☐	HIV / AIDS
☐	☐	Kaposi's Sarcoma
☐	☐	Bleeding or brusing easily
☐	☐	Sudden weight loss or gain
☐	☐	Frequent thirst
☐	☐	Frequent hunger
☐	☐	Frequent urination
☐	☐	Autoimmune disorders/ Lupus

Psychiatric Disorders:

Yes	No	
☐	☐	Depression
☐	☐	Anxiety / Nervousness
☐	☐	Eating disorders
☐	☐	Past / present psychiatric treatment

Is there anything else we should know about your medical history?

_____

Family history (Grandparents, Parents, Siblings):

Yes	No	
☐	☐	Diabetes
☐	☐	Heart Disease
☐	☐	Bleeding disorder
☐	☐	Cancer

Allergies:

Yes	No	
☐	☐	Penicillin or other antibiotics
☐	☐	Sulfa drugs
☐	☐	Novocaine / Dental anesthetics
☐	☐	Aspirin
☐	☐	Codeine or other narcotics
☐	☐	Latex products
☐	☐	Metals / Plastics / Sulfites
☐	☐	Hay fever / seasonal allergy
☐	☐	Sedatives or sleeping pills
☐	☐	Others: _____

Females:

Yes	No	
☐	☐	Pregnant
☐	☐	Anticipate being pregnant
☐	☐	Taking birth control pills
☐	☐	Breast feeding

Cancer/ Tumor :

Yes	No	
☐	☐	Diagnosis _____ Year _____
☐	☐	Surgery _____
☐	☐	Radiation _____
☐	☐	Chemotherapy _____

Medications (Including aspirin and herbal supplements):

Yes	No	
☐	☐	_____ _____ _____ _____ _____

Social history (Past / Present):

Yes	No	
☐	☐	Smoking
☐	☐	Smokeless tobacco
☐	☐	Alcohol drinks per week _____
☐	☐	Substance abuse

I certify that above information is correct to the best of my knoweldge. I agree to keep this office inform of any changes in my health or any medications I may be taking.

Date _____ Signature of Patient, Parent or Guardian _____ Reviewed by _____

Expectations Regarding Appointments

To Our Clients

At Shor Dental we work very hard at treating our clients as unique individuals. We try to remain responsive to each person's needs, preferring to rely on common sense and common courtesy rather than hard and fast "Policies". Unlike many dental practices where the dentist bounces from room to room, we see only one client at a time. When you book an appointment with us, you have our undivided attention for the length of that appointment.

Short-notice cancellations or missed appointments affect many people. From an operations standpoint, missed appointments increase our cost of providing dental care - costs that ultimately must be passed on to you, our client. More importantly, missed appointments do not allow us the opportunity to offer the appointment time to other clients needing - and wanting - care.

For these reasons we are asking you to read and agree to these expectations:

1. Please respect our time and that of other clients by giving us a minimum of *two business days' notice* to cancel or change an appointment.

2. For cancellations or missed appointments where less than two business days' notice is given, a charge of $100.00 per hour of scheduled time will be made.

Such policies have been standard practice for other health care providers who work one-on-one with their clients. We thank you in advance for your understanding.

Signed: _____ Date: _____

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 REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) requires all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, to be kept confidential. This federal law gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information. As required by law, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

Without specific written authorization, we are permitted to use and disclose your health care records for the purposes of treatment, payment **and health care operations.**

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, we may disclose treatment information when billing a dental plan for your dental services.
- **Health Care Operations** include the business aspects of running our practice. For example, patient information may be used for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health-related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have certain rights in regards to your protected health information, which you may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to request to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information, with limited exceptions. A reasonable fee may be assessed.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operations...or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect **to** protected health information.

This notice is effective as of_____ , 2003, and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. Revisions to our Notice of Privacy Practices will be posted on the effective date and you may request a written copy of the Revised Notice from this office.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our Privacy Practices, please contact:

Privacy Officer Ruth Egbert
Office Name Shor Dental
Address 1500 Fairview Ave E #300
City, State, Seattle, WA 98102
Phone 206-325-7456

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights 200
Independence Avenue, S.W.
Washington, D.C. 20201

877-696-6775 (toll-free)

ACKNOWLEDGEMENT
OF PRIVACY
PRACTICES

Shor Dental
1500 Fairview Avenue, East, #300
Seattle, WA 98102
206-3257456

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 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 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: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

_____

_____

For Office Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- ☐ The patient refused to sign
- ☐ Communication barriers
- ☐ Emergency situation
- ☐ Other