

Statement of Privacy Practices

Sequim Family Dentistry

Our office is dedicated to protecting 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 Personal 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.

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Sequim Family Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Sequim Family Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
<i>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 is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)</i>		
Spouse only	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Any Member of my extended family: (Parents, Grandchildren)	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Other:	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Name of patient (please print): _____		
Patient signature: _____		
Patient's personal representative: (Please Print): _____		
Personal Representative's signature: _____		
Representative's Telephone Number: _____ Date: _____		

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	Date Statement Provided: _____
Reason for not obtaining patient signature	<input type="checkbox"/>	Needed more time to review Statement	
	<input type="checkbox"/>	Wanted to consult another person before signing	
	<input type="checkbox"/>	Physically unable to sign	
	<input type="checkbox"/>	No reason offered	
	<input type="checkbox"/>	Other: _____	

Sequim Family Dentistry – Health History Update

321 N Sequim Ave Ste B 360-681-8884(TUTH)

sequimfamilydentistry@yahoo.com

<p>Why have you come to the dentist today? _____</p> <p>_____</p> <p>Are you currently in pain? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you require antibiotics before dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you APREHENSIVE about dental treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you experienced problems associated with any previous dental work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you aware of GRINDING or CLENCHING your teeth <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Have you worn BRACES on your teeth? (ORTHODONTICS) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have dry mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do your gums BLEED, feel TENDER or are IRRITATED? (if yes, please circle which) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Have you ever had periodontal disease? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you have mobility in your teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are your teeth sensitive to heat, cold, or anything else? _____</p> <p>Previous/Present Dentist _____ Last Visit Date _____</p> <p>City & State _____</p> <p>Are you happy with the way your smile looks? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If not, what would you like to change? _____</p>
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MEDICAL HISTORY

<p>Do you have a primary care physician? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Physician's Name: _____</p> <p>Address: _____</p> <p style="text-align: center;">Street City State Zip</p> <p>Phone #: (____) _____ Date of last visit: _____</p>	<p>How is your current physical health? <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor</p> <p>Has there been a change in your health in the last year? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do you smoke or use tobacco in any other form? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Week #: _____ Are you nursing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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MEDICATIONS (you may attach a list if necessary)

LIST ALL ALLERGIES

Medication Name	Dosage	Reason for Taking	

Please Circle "Yes" to any of the following which apply:

Y N Abnormal Bleeding	Y N Chicken Pox	Y N Hay Fever	Y N Kidney Problems	Y N Seizures
Y N Alcohol Abuse	Y N Colitis	Y N Headaches	Y N Liver Disease	Y N Shingles
Y N Anemia	Y N Congenital Heart Defect	Y N Heart Attack	Y N Low Blood Pressure	Y N Sickle Cell Dis.
Y N Angina Pectoris	Y N Diabetes	Y N Heart Murmur	Y N Lupus	Y N Sinus Problems
Y N Arthritis	Y N Difficulty Swallowing	Y N Heart Surgery	Y N Mitral Valve Prolapse	Y N Steroid Therapy
Y N Artificial Bones/Joints	Y N Drug Abuse	Y N Hemophilia	Y N Osteoporosis	Y N Stroke
Y N Artificial Valves	Y N Emphysema	Y N Hepatitis/ A B C	Y N Pacemaker	Y N Thyroid Problems
Y N Asthma	Y N Epilepsy	Y N Herpes	Y N Psychiatric Problems	Y N Tonsillitis
Y N Blood Transfusion	Y N Fainting Spells	Y N High Blood Pressure	Y N Radiation Treatment	Y N Tuberculosis (TB)
Y N Cancer	Y N Fever Blisters	Y N HIV+/AIDS	Y N Rheumatic Fever	Y N Ulcers
Y N Chemotherapy	Y N Glaucoma	Y N Hospitalized (specify below)	Y N Scarlet Fever	Y N Venereal Disease

Please list any serious medical condition(s) you have experienced, including date:

Authorizations

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that where appropriate, credit bureau reports may be obtained. A late fee of \$25 may be incurred for monthly balances unpaid.

I certify that I am covered by _____ insurance co. and I assign benefits directly to Dr. Brian Juel, D.D.S., otherwise payable to me. I understand that I am responsible for payment of services rendered as well as any co-pays, deductibles or other services that my insurance does not cover. A late fee of \$25 may be incurred for monthly balances left unpaid. I hereby authorize the dentist to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my submissions, whether manual or electronic.

Signature _____

Date _____

Signature _____

Date _____



Welcome to Sequim Family Dentistry
 Dr. Brian Juel DDS P.S. & Dr. Nathan E. Gelder DMD
 321 N Sequim Ave. #B/ PO Box 3430
 360-681-8884 (TUTH)
www.sequimfamilydentistry.com

PATIENT INFORMATION

Full Name: _____ I prefer to be called: _____
 Male: ___ Female: ___ Birthdate: ___/___/___ Age: ___ SSN# (if billing insurance): _____
 Home Address: _____
 How long at this address? _____ years
 Mailing Address (if different than home address): _____
 Home Phone #: (____) _____ Work #: (____) _____
 Cell#: (____) _____ Email address: _____
How do you prefer to receive billing statements? E-mail USPS mail Both mail & e-mail
 Employer: _____ # Years Employed: ___ Occupation: _____
 Whom may we thank for referring you? _____

SPOUSE INFORMATION (if applicable)

Spouse's Name: _____ Birth Date: ___/___/___ SSN#: _____

EMERGENCY CONTACT

Name: _____ Phone #: (____) _____ Relationship _____

DENTAL INSURANCE INFORMATION (if applicable)

Primary Dental Insurance:

Insurance Company Name: _____ Phone #: (____) _____

Insurance Co. Billing Address: _____

Subscriber Name: _____ Relationship to patient: _____

Subscriber Date of Birth ___/___/___ Subscriber ID #: _____ Group #: _____

Secondary Dental Insurance:

Insurance Company Name: _____ Phone #: (____) _____

Insurance Co. Billing Address: _____

Subscriber Name: _____ Relationship to Patient: _____

Subscriber Date of Birth ___/___/___ Subscriber ID #: _____ Group #: _____

(OVER)