Welcome to Sequim Family Dentistry
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)

Sequim Family Dentistry – Health History Update

321 N Sequim Ave Ste B   360-681-8884(TUTH)   sequimfamilydentistry@yahoo.com

Why have you come to the dentist today? ______________________

____

Are you currently in pain? ☐Yes ☐No

Do you require antibiotics before dental treatment? ☐Yes ☐No

Are you APREHENSIVE about dental treatment? ☐Yes ☐No

Have you experienced problems associated with any previous dental work? ☐Yes ☐No

Do you now or have you ever experienced pain/ discomfort in your jaw joint (TMJ/TMD) ☐Yes ☐No

Are you aware of GRINDING or CLENCHING your teeth ☐Yes ☐No

Have you worn BRACES on your teeth? (ORTHODONTICS) ☐Yes ☐No

Do you have dry mouth? ☐Yes ☐No

Do your gums BLEED, feel TENDER or are IRRITATED? (if yes, please circle which) ☐Yes ☐No

Have you ever had periodontal disease? ☐Yes ☐No

Do you have mobility in your teeth? ☐Yes ☐No

Are your teeth sensitive to heat, cold, or anything else?

____

Previous/Present Dentist______________ Last Visit Date _____

City & State ____

Are you happy with the way your smile looks? ☐Yes ☐No

If not, what would you like to change? __________________

MEDICAL HISTORY

Do you have a primary care physician? ☐Yes ☐No

Physician's Name:______________________________________

Address:____

Street City State Zip

Phone #: (____) _______________ Date of last visit: ___________

How is your current physical health? ☐Good ☐ Fair ☐Poor

Has there been a change in your health in the last year? ☐Yes ☐No

Do you smoke or use tobacco in any other form? ☐Yes ☐No

Are you pregnant? ☐Yes ☐No

Week #: Are you nursing? ☐Yes ☐No

MEDICATIONS (you may attach a list if necessary)

Medication Name	Dosage	Reason for Taking

LIST ALL ALLERGIES

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	Osteoperosis	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.

Signature Date

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

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.

Sequim Family Dentistry
321 North Sequim Avenue / PO Box 3430 * Sequim, Washington * 98382 * 360-681-8884

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		
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.)		
Spouse only	☐ **YES**	☐ **NO**
Any Member of my immediate family: (Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (Parents, Grandchildren)	☐ **YES**	☐ **NO**
Other:	☐ **YES**	☐ **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?	☐ YES	☐ NO	Date Statement Provided:
Reason for not obtaining patient signature	☐	Needed more time to review Statement	
	☐	Wanted to consult another person before signing	
	☐	Physically unable to sign	
	☐	No reason offered	
	☐	Other:	

Sequim Family Dentistry
321 North Sequim Avenue / PO Box 3430 * Sequim, Washington * 98382 * 360-681-8884