

## Patient Registration

Patient Name \_\_\_\_\_ Today's Date: \_\_\_\_\_  
Mailing Address \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Email: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Birth Date: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_ SSN: \_\_\_\_\_ Sex: Male Female  
Marital Status: Single Married Widowed Divorced Spouses Name: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
Employer: \_\_\_\_\_  
How did you hear about our office? \_\_\_\_\_

### **Responsible Party:**

Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Mailing Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Social Security: \_\_\_\_\_ Birth Date: \_\_\_/\_\_\_/\_\_\_  
Driver's License: \_\_\_\_\_ Custodial Parent: Yes No Other or N/A

### **Dental Insurance Information:**

PRIMARY INSURANCE: _____	SECONDARY INSURANCE: _____
Employer: _____	Employer: _____
Subscriber's Name: _____	Subscriber's Name: _____
ID# or SS#: _____	ID# or SS#: _____
DOB: _____ Group# _____	DOB: _____ Group# _____

Patient Signature (parent if minor): \_\_\_\_\_ Date: \_\_\_\_\_

## **HEALTH HISTORY**

<b>Name:</b>	<b>SEX:</b> <input type="checkbox"/> M <input type="checkbox"/> F
<b>Today's Date:</b>	<b>DOB:</b>

Reason for your visit today:		
Date of last dental visit:		
Last dental cleaning:	Previous Dentist:	
How often do you have dental exams?		
Do you have any dental problems now?    Explain:		
How often do you brush your teeth?		
How often do you floss?		
What other dental aid do you use? (Interplak, toothpick, etc.)?		
Have you ever used or are you currently using topical fluoride?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>ARE ANY OF YOUR TEETH SENSITIVE TO:</b>		
Hot or cold?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sweets?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Biting or Chewing?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you noticed any mouth odors or bad taste?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you frequently get cold sores, blisters, or any other oral lesions?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your gums bleed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have your parents experienced gum disease or tooth loss?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you noticed any loose teeth or change in your bite?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does food tend to become caught in between your teeth?    If so where?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>DO YOU:</b>		
Clench or grind your teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bite your lips or cheeks regularly?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hold foreign objects with your teeth? (pencils, pipe, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mouth breathe while awake or asleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have tired jaws, especially in the morning?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Snore or have any other sleep disorders?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Smoke/chew tobacco or use tobacco products?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>HAVE YOU EVER HAD:</b>		
Orthodontic treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Oral surgery?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Periodontal treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Your teeth ground or the bite adjusted?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A bite plate or mouth guard?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
A serious injury to the mouth or head?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>HAVE YOU EXPERIENCED:</b>		
Clicking or popping of the jaw?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Pain? (joint, ear, side of face)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Difficulty in opening or closing the mouth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Headaches, neck aches or shoulder aches?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## DENTAL HISTORY:

Do you feel nervous about having dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever had an upsetting dental experience?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you ever been told to take pre-medication prior to dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to replace your silver fillings?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Would you like to keep all of your teeth all your life?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you satisfied with your teeth's appearance?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

## MEDICAL HISTORY:

Physician's Name:	Phone number:
Have you taken any medication or drugs during the last two years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list name and dosage:	
Are you currently taking any medication, drugs, pills, or herbal remedies, including regular dosages of aspirin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list name and dosage:	
Have you ever taken bone loss prevention drugs such as Fosamax, Actonel, Boniva or other bisphosphonates?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please list name and dosage:	
Are you aware of having an allergic (or adverse) reaction to any substance or medication	<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, please specify:	
Have you been a patient in the hospital during the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you lost or gained more than 10 pounds in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have or have you had any disease, condition, or problem not listed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
WOMEN: Are you pregnant or think you could be?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use birth control pills?	<input type="checkbox"/> Yes <input type="checkbox"/> No

## HAVE YOU EVER HAD OR DO YOU HAVE:

Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Thyroid Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Glaucoma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Contact Lenses	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Emphysema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chronic Cough	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hay Fever/Allergy/Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Latex Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sinus Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Radiation Therapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Tumors	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Heart (Surgery, Disease, Attack)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Chest Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Congenital Heart Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
High/low Blood Pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Mitral Value Prolapse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Heart Value/Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Rheumatic Fever	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Arthritis/Rheumatism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cortisone Medicine	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Swollen Ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diet (Special/Restricted)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Artificial Joints (hip, knee, etc.)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Kidney Trouble	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Hepatitis A B C (circle)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Venereal Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
AIDS/HIV Positive	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cold Sores/Fever Blisters	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Blood Transfusion	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hemophilia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sickle Cell Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Bruises Easily	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Liver Disease/Yellow Jaundice	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Neurological Disorders	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Fainting or Dizzy Spells	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Nervous/Anxious	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Psychiatric/Psychological Care	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any changes in my health or medication.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# Occlusal Screening

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

Many people experience symptoms that they feel are “normal” or are caused by other things such as allergies and stress. Many of these symptoms can actually be related to a “bad bite” Please take a moment to look over the screening symptoms below. Please check the appropriate line if you are experiencing or have experienced any of these in the past. Please feel free to ask us any questions.

- Headaches
- Migraines
- TMJ Noise (popping or clicking)
- Limited Opening
- Ear Congestion
- Vertigo
- Tinnitus (ringing in the ears)
- Tearing (of the eyes for no apparent reason)
- Dysphagia (difficulty swallowing)
- Loose teeth
- Clenching/Bruxing/Grinding
- Facial Pain
- Retro- orbital pain (pain behind the ears)
- Tender, sensitive teeth
- Difficulty chewing
- Snoring/Sleep Apnea
- Cervical Pain (Sore neck muscles)
- Postural Problems
- Paresthesia of fingertips (tingling in arms, hands or fingers)
- Tooth Thermal Sensitivity (hot and cold)
- Sore Jaw Muscles Upon Waking
- Dry Mouth
- Trigeminal Neuralgia (facial sagging)
- Bell's Palsy
- Nervousness/ Insomnia



# Your Personal Smile Evaluation

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

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

**Do you prefer:** Holistic Dentistry

Traditional Dentistry

Combination of both

## When I see a picture of myself:

\_\_\_ I wish my teeth were whiter

\_\_\_ I wish I had a broader smile

My teeth are \_\_\_ crowded \_\_\_ crooked \_\_\_ uneven \_\_\_ overlapped

\_\_\_ My teeth have rough edges

My gums show \_\_\_ too much \_\_\_ not enough

\_\_\_ My top teeth don't show enough

\_\_\_ There is too much space between my teeth

\_\_\_ I have discolored areas between my teeth

\_\_\_ I am not totally please with my smile

\_\_\_ I am interested in options available for enhancing my smile

## Billing & Insurance

We make every effort to provide you with the finest care and the most convenient financial options. In the interest of both medicine and good business, we believe it's the best to establish a fair financial policy to avoid any misunderstandings later. **DO NOT** hesitate to ask questions about the cost of your dental treatment. You have a right to know and understand our charges as well as your own insurance benefits. As a result we have adopted the following financial policies:

### Fee & Payment Policy

A written estimate will be provided for you on all treatment plans. Estimated **patient portion** is required to reserve a day with the Doctor for all complex restorative and cosmetic treatment, regardless of insurance coverage.

1. Payment of the estimated **patient portion** is due at scheduling the appointment. We accept Visa, MasterCard, and American Express. We also offer Care Credit, an interest free financing program 6-12 months. As a courtesy, Dr. Fisher pays the interest. Visit [www.carecredit.com](http://www.carecredit.com).
2. A **5% courtesy** discount is offered to our **uninsured** patients who pay by **cash** or **check**. Patients that have large cases and pay in full with cash or check (no credit cards) will also receive a **5% courtesy**.
3. Accounts over 60 days may be charged a 1.5% monthly fee.
4. Accounts over 90 days past due may be assigned to a collections company.

### Credit Card & Billing Policy

As of January 1, 2018, Dr. Kelley Fisher will ask all clients to provide a debit or credit card to keep on file in our **secure** electronic medical records program. *Your provider will collect any payments due at the time of service by credit card, check or cash.* A client who wishes to change their credit card on file may do so by phone 425-392-1256 or at any dental visit.

I hereby authorize Dr. Kelley Fisher, DDS, to run my credit/debit card(listed below) for any balance I accrue for services provided. I understand my card will be run without prior notice to myself.

#### Credit Card Information:

Name on card: \_\_\_\_\_

Card # \_\_\_\_\_ Exp Date \_\_\_\_\_ Sec Code \_\_\_\_\_

Complete Billing Address: \_\_\_\_\_  
\_\_\_\_\_

Authorized signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Cancellations

Please give our office **48 hour notice** if you need to reschedule your appointment. Appointments rescheduled **after** that period will incur a charge of **the full appointment price** for hygiene appointments, and **patient portion** for appointments with Dr Fisher. By chance, if a scheduled appointment is missed, the same charge will incur. Your insurance company will not cover cancellation charges.

Thank you for your commitment to our practice and we promise to ensure excellent and timely care to you, your family, and friends.

### Insurance Information

We are a participating provider with most dental insurance companies and maintain a "preferred provider" status with Aetna, Premera Blue Cross and Regence. As a courtesy we will file your insurance claims for you and accept assignment of benefit. Please maintain a copy of your plan benefits and alert us as to any changes. Your insurance policy is an agreement between your employer and the insurance company. While we will work closely to maximize your insurance coverage, every plan is uniquely different and plans change constantly. It is not possible for us to know the various clauses and individualities of every plan. Because of this, we can only provide an estimate for services rendered. For the most accurate estimate, please consult with the director of your plan. Should your insurance company pay less than expected, you will be responsible for the balance. If your insurance company pays more than we estimated, you will receive a refund. Please feel free to ask a financial coordinator if you have any questions about the cost of care.

I have read and understood the Billing, Credit Card on File and Insurance Policies for the practice of Kelley Fisher DDS, PLLC.

### Photographic Release

In our office we like to photograph our patients to aid in proper diagnoses. Dr. Fisher also uses these photographs to teach other dentist and design beautiful smiles. In addition, we are proud of the work we do and like to use our own work to show other patients our beautiful results.

I \_\_\_\_\_, hereby authorize Dr. Kelley Fisher to take photographs, slides, and/or videos of my face, jaws and teeth. I understand that the photographs, slides, and/or videos will be used as a record of my care, advertising (including Facebook, Instagram, website publication, magazines, television), and professional publications (dental magazines and journals). I further understand that if the photographs, slides, and/or videos are used in any publication or a part of a demonstration, my name or other identifying information will be kept confidential. I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by our practice.

Patient Name (Print):

Relationship to Patient:

\_\_\_\_\_

\_\_\_\_\_

Patient Signature/Guardian:

Date:

\_\_\_\_\_

\_\_\_\_\_

### ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Kelley Fisher, DDS, PLLC  
22620 SE 4<sup>th</sup> St, Ste 220  
Sammamish, WA 98074  
425-392-1256

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 by my dental provider's Notice of Privacy Practices, that contain 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 patients written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Other

### NOTICE OF PRIVACY PRACTICES

This notice describes how medial information about you may be used and disclosed and how you can get access to this information. The Health Insurance Portability and Accountability Act of 1996 (HIPPA) required all health care records and other individually identifiable health information used or disclosed to us in any form, whether electronically, on paper, or orally, be kept confidential. This federal law gives you the patient, significant new rights to understand and control how your health information is used. HIPPA provides penalties for covered entities that misuse personal health information. As required by HIPPA, 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.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review.
- Health Care Operations include the business aspects of running our practice.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use our confidential information to remind you of an appointment by sending reminder postcards, emails, text messages and/or leaving messages at home, work, and/or cell. Any other uses and disclosures will be made only with your written authorization.

You have certain rights in regards to your protected health information, which you can 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 from us by alternative means or at alternative locations.
- The right to request to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to access, inspect, and copy your protected health information.
- The right to request an amendment of your protected health information.
- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.
- The right to obtain a paper copy of this notice from us upon request.

We require 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 February 01, 2005, and we are required to abide to the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the term 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 and 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 your Privacy Practices, please contact for more information about HIPPA or to file a complaint:

Kelley Fisher  
22620SE 4<sup>th</sup> St, Ste 220  
Sammamish, WA 98074

Office of Civil Rights  
200 Independence Ave SW  
Washington, D.C. 20201 877-696-6775