PREMIER
PERIODONTICS
ALWAYS HERE FOR YOU
WWW.PREMIERPERIODONTICS.COM

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Welcome! We are genuinely pleased that you have chosen Premier Periodontics for your complete periodontal care. ***Please visit us: www.PremierPeriodontics.com***

WHO WE ARE:

Our Premier Periodontics Board Certified Doctors are fully committed to providing patients the highest quality state-of-the-art periodontal procedures in a relaxed, caring and comfortable environment. Voted 'Best Seattle Dentists' year over year, Premier Periodontics Doctors are well known for explaining available treatment options so patients will better understand their optimal recommended procedures. Our 4 convenient eastside locations offer patients multiple weekday appointment options to fit busy schedules and our professional and engaging staff welcomes the opportunity to serve your dental needs.

WHAT PATIENTS CAN EXPECT:

Referred patients to Premier Periodontics are scheduled for an initial exam based on their dentist's request. The entire Premier Periodontal Team collaborates closely with your referring dentist from requesting your current dental records required for your exam to providing your referring dentist with your complete exam findings, any recommended treatment and your ongoing treatment progress.

YOUR INITIAL EXAM:

To provide you with the most optimal care, Premier Periodontics requires patients to complete the attached health history information prior to any scheduled exam. At the time of your exam, one of our experienced Registered Surgical Assistants will review your completed medical/dental health history with you to document any medical conditions, prior surgeries, current medications and to learn any dental concerns. This important medical/dental history information guides the Doctor when providing patients their optimal treatments and expected outcomes.

RECOMMENDED TREATMENT AND FINANCIAL PLANNING:

Our knowledgeable Treatment Coordinators provide patients all available financial planning options based on a recommended treatment plan. Whether you have dental insurance benefits or not, the majority of our patients discover there is a financial planning option to satisfy their requirements. Our friendly staff will assist you to finalize the best plan for you.

OUR COMMITMENT TO YOU:

Premier Periodontics has set aside a designated amount of time just for you and your appointment. We know patients make every effort to keep their appointments and, as a courtesy to all our scheduled patients, we ask that if you must miss your appointment, that we are notified by email or telephone at least 48 hours prior to your appointed time. Without a 48-hour cancellation notification, Premier Periodontics will apply a 'no show' patient charge to your account.

Our Staff Looks Forward To Meeting You Soon!

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Bellevue
Everett
Kirkland
Mercer Island
Redmond

PATIENT PERSONAL INFORMATION						
Today's date:	**Date reviewed/updated:**				**Initial here** _____	
Title:	Last name:	First:	Middle:	Nickname:	Birth date:	Age:
Address:				Cell Phone:	Marital Status:	Sex: ☐ M ☐ F
City, State, Zip:	Home Phone:			Work Phone:		
E-mail:	Referred by:					
Person responsible/guarantor for paying bills:						
Title:	Last name:	First:	Middle:	Nickname:	Birth date:	Age:
Address:				Cell Phone:	Marital Status:	Sex: ☐ M ☐ F
City, State, Zip:	Home Phone:			Work Phone:		
Do you have Primary Dental Insurance? ☐ **Yes** ☐ **No**	Name of Current Insurance Carrier?					
Do you have Secondary Dental Insurance? ☐ **Yes** ☐ **No**	Name of Current Insurance Carrier?					

EMERGENCY CONTACT:	
Emergency contact name/Relation to patient:	Phone:

DENTAL QUESTIONNAIRE
Name of current dentist:
Reason for today's visit:
Last visit with your dentist:
Do you floss regularly?
Do your gums bleed while brushing or flossing?
Are your teeth sensitive to hot, cold or sweets?
Do you chew/smoke tobacco in any form?
Have you had any head, neck or jaw injuries?
Do you notice popping, clicking or soreness of your jaw?
Do you clench or grind your teeth?
Have you ever had orthodontic treatment?
Do you wear dentures or partials?
Have you ever been told you have gum disease?
Any other dental issues?

PATIENT MEDICAL INFORMATION								
Check yes or no:								
Allergies:								
Penicillin	Y ☐ N ☐		Local Anesthetics	Y ☐ N ☐		Iodine	Y ☐ N ☐	
Sulfa Drugs	Y ☐ N ☐		Aspirin	Y ☐ N ☐		Latex Rubber	Y ☐ N ☐	
Erythromycin	Y ☐ N ☐		Codeine	Y ☐ N ☐				
Other Allergies:								
Kidney Disease	Y ☐ N ☐		Arthritis	Y ☐ N ☐		Stroke	Y ☐ N ☐	
Alcohol/Drug Abuse	Y ☐ N ☐		Rheumatic Fever	Y ☐ N ☐		Heart Attack	Y ☐ N ☐	
Congestive Heart Failure	Y ☐ N ☐		AIDS/HIV Infection	Y ☐ N ☐		Blood Transfusion	Y ☐ N ☐	
Blood Clotting Problems	Y ☐ N ☐		Rheumatic Heart Disease	Y ☐ N ☐		Heart Murmur	Y ☐ N ☐	
Emphysema	Y ☐ N ☐		Angina/Chest Pain	Y ☐ N ☐		Cardiac Pacemaker	Y ☐ N ☐	
Hives	Y ☐ N ☐		CPAP User	Y ☐ N ☐		Diabetes	Y ☐ N ☐	
Tuberculosis	Y ☐ N ☐		Stomach Ulcers	Y ☐ N ☐		Anemia	Y ☐ N ☐	
Mitral Valve Prolapse	Y ☐ N ☐		Sleep Apnea	Y ☐ N ☐		Bulimia	Y ☐ N ☐	
High Blood Pressure	Y ☐ N ☐		Fainting Spells	Y ☐ N ☐		Asthma	Y ☐ N ☐	
Cancer/Tumor or Growth	Y ☐ N ☐		Bronchitis	Y ☐ N ☐		Thyroid Problems	Y ☐ N ☐	
Frequent Headaches	Y ☐ N ☐		Sinus Trouble	Y ☐ N ☐		Lupus	Y ☐ N ☐	
Shortness of Breath	Y ☐ N ☐		Joint Replacement	Y ☐ N ☐		Seizures	Y ☐ N ☐	
Radiation/Chemo-therapy	Y ☐ N ☐		Dry Mouth/Sjogren	Y ☐ N ☐		Gag Reflex	Y ☐ N ☐	
Cardiovascular/Heart Disease	Y ☐ N ☐		Do you Pre-Medicate with Antibiotic?	Y ☐ N ☐		Hay Fever	Y ☐ N ☐	
Hepatitis: A, B or C	Y ☐ N ☐		Sexually Transmitted Disease	Y ☐ N ☐				

Have you had any serious illinesses, operations, been hospititalized in the last 5 years or any other medical issues or concerns not listed above?

Women Only:

Are you pregnant? Y ☐ N ☐	Are you currently nursing? Y ☐ N ☐	Are you on birth control pills? Y ☐ N ☐

MEDICAL QUESTIONNAIRE

Family Physician:	Phone:

Are you currently under the care of your physician?

If yes, what is the condition being treated?

Are you currently taking any medication? If so, please list:

_____ _____

_____ _____

_____ _____

_____ _____

Have you taken bisphosphonates? (Fosamax, Boniva, Zometa, Actonel, Didronel, Aredia, Skelid, Reclast) Y ☐ N ☐

BY SIGNING BELOW, I CERTIFY THAT ALL OF THE ABOVE INFORMATION IS TRUE AND TO THE BEST OF MY KNOWLEDGE.

_____ _____

Patient/Guardian Signature Date

Acknowledgement of Privacy Practices

My signature confirms that I have been informed of my rights of 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* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy* .

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.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the person(s) indicated below.

☐ **ANY MEMBER OF MY IMMEDIATE FAMILY** ☐ **SPOUSE ONLY:** _____

☐ **Other (please specify):** _____

Patient Name: _____ Date: _____

Signature: _____

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PREMIER PERIODONTICS PATIENT POLICIES

Cancelled/No Show Appointments

We know patients make every effort to keep their appointments. Premier Periodontics has set aside a designated amount of time for your scheduled appointment with the doctor and/or the hygienist. A 48-hour cancellation policy applies to all scheduled appointments. There will be a patient account charge of $100.00 for missed Hygiene and/or Doctor exams. For missed surgical procedures, a deposit equal to 30% of your estimated patient portion will be due upon rescheduling and applied toward the treatment upon completion.

Late Arrivals Policy

Traffic and tight schedules can delay patient arrivals. Premier Periodontics truly appreciates timely and even early patient arrivals and will make every reasonable effort to fit in scheduled, but minimally late arrivals. Patients who believe they will be more than 5 minutes late should call ahead to determine if their late arrival of over 5 minutes and our fully scheduled day will be a conflict to provide them our best possible care.

Financial Payment Policy

Premier Periodontics accepts cash, personal check, Visa, MasterCard, American Express, Discover credit cards and CareCredit financing. For more information about CareCredit financing please visit: http://www.carecredit.com/howcarecreditworks/ Any outstanding balance of over 90 days is forwarded to collections.

Insurance:

Patients are responsible for their treatment costs not covered by their insurance carrier. Dental/Medical Plans are a contract between the patient and their insurance carrier. All patient treatment charges are the responsibility of the patient or the patient's responsible party regardless of any provided insurance carrier predeterminations and/or insurance estimations or coverage.

As a Patient Courtesy, We Assist to Coordinate Insurance Carrier Benefits

To coordinate payment of any insurance carrier benefits, the Premier Periodontics staff will ask you for your insurance carrier name, the subscriber's identifier information and employer and to scan your insurance card and/or driver's license per all insurance carriers' requests to verify the patient's ID. The Premier Periodontal staff will also request your insurance carrier predetermination of treatment coverage and this document will be provided to you (and Premier Periodontics) within 7-10 days of your recommended treatment plan by your insurance carrier.

No Insurance:

Exams/Emergencies/Hygiene: Full payment is due at the time of your appointment.
Multiple Visit Payment Options: Depending upon your treatment plan cost, a financial payment plan will be provided to include options of one or more payments and/or a CareCredit financing plan.

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NOTICE OF PRIVACY PRACTICES

PREMIER PERIODONTICS

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 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 HIPAA, 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, payments and health care operations.

- TREATMENT means providing, coordination, or managing health care and related services by one of more health care providers. For example, we may need to share information with other 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 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, or other personal representative to the extent necessary to help with your healthcare of with payment. In addition, we may use your confidential information to remind you of appointments by leaving messages at home and/or cell phone. 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 can exercise by presenting a written request to our Privacy Officer at the practice listed above.

- 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 request restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right 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.
- The right to request an amendment to 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 are required by law to maintain the privacy of 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 April 13, 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 four 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.

For more information about our Privacy Practices, please contact:
The U.S. Department of Health & Human Services Offices of Civil Rights
200 Independence Ave. SW
Washington, DC 20201 (1-877-696-6775)