



Kristopher A. Johnson, D.D.S.

# Harbour Pointe Family Dentistry

Date \_\_\_\_\_ Home Phone (\_\_\_\_\_) \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

### PATIENT INFORMATION

Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
Last Name First Name Middle Initial

Address \_\_\_\_\_ E-Mail: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Sex  M  F Age \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Married  Divorced  Single  Minor  
 Separated  Widowed  Partnered

Patient Employer/School \_\_\_\_\_ Occupation \_\_\_\_\_

Employer/School Address \_\_\_\_\_ Employer/School Phone (\_\_\_\_\_) \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

In case of emergency who should be notified? \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Person Responsible for Account \_\_\_\_\_  
Last Name First Name Initial

Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### INSURANCE

Is patient covered by insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Soc. Sec. # / I.D. # \_\_\_\_\_

Name of other dependents covered under this plan \_\_\_\_\_

### ADDITIONAL INSURANCE

Is patient covered by additional insurance?  Yes  No

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Relation to Patient \_\_\_\_\_

Address (if different from patient's) \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber Employed by \_\_\_\_\_ Business Phone (\_\_\_\_\_) \_\_\_\_\_

Insurance Company \_\_\_\_\_ Cell Phone (\_\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Soc. Sec. # / I.D. # \_\_\_\_\_

Name of other dependents covered under this plan \_\_\_\_\_

### ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have Insurance coverage with \_\_\_\_\_ and assign directly to  
Name of Insurance Company(ies)

Harbour Pointe Family Dentistry all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance. I authorize the use of my signature on all insurance information.

The above named physician may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient

**DENTAL HISTORY**

Reason for Today's Visit \_\_\_\_\_ Date of last dental care \_\_\_\_\_

Former Dentist \_\_\_\_\_ Date of last dental X-rays \_\_\_\_\_

Address \_\_\_\_\_

Check (✓) if you have had problems with any of the following:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Bad breath                    | <input type="checkbox"/> Grinding teeth                 | <input type="checkbox"/> Sensitivity to hot             |
| <input type="checkbox"/> Bleeding gums                 | <input type="checkbox"/> Loose teeth or broken fillings | <input type="checkbox"/> Sensitivity to sweets          |
| <input type="checkbox"/> Clicking or popping jaw       | <input type="checkbox"/> Periodontal treatment          | <input type="checkbox"/> Sensitivity when biting        |
| <input type="checkbox"/> Food collection between teeth | <input type="checkbox"/> Sensitivity to cold            | <input type="checkbox"/> Sores or growths in your mouth |

How often do you floss? \_\_\_\_\_ How often do you brush? \_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ Date of Last Visit \_\_\_\_\_

Have you had any serious illnesses or operations? \_\_\_\_\_ If yes, describe \_\_\_\_\_

Have you ever had a blood transfusion?  Yes  No If yes, give approximate dates \_\_\_\_\_

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?"  Yes  No

Have you ever taken Fosamax or any other bisphosphonates?  Yes  No

(Women) Are you pregnant?  Yes  No Nursing?  Yes  No Taking birth control pills?  Yes  No

Check (✓) if you have or have had any of the following:

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Cortisone Treatments | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Arthritis, Rheumatism   | <input type="checkbox"/> Cough, Persistent    | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shortness of Breath        |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Cough up Blood       | <input type="checkbox"/> HIV/AIDS              | <input type="checkbox"/> Skin Rash                  |
| <input type="checkbox"/> Artificial Joints       | <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Jaw Pain              | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Epilepsy             | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Swelling of Feet or Ankles |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Fainting             | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Problems           |
| <input type="checkbox"/> Blood Disease           | <input type="checkbox"/> Glaucoma             | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tobacco Habit              |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> Headaches            | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Chemical Dependency     | <input type="checkbox"/> Heart Murmur         | <input type="checkbox"/> Radiation Treatment   | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Chemotherapy            | <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Respiratory Disease   | <input type="checkbox"/> Ulcer                      |
| <input type="checkbox"/> Circulatory Problems    | <input type="checkbox"/> Hemophilia           | <input type="checkbox"/> Rheumatic Fever       | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Other _____             |   |  |   |

**MEDICATIONS**

List medications you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_

Phone \_\_\_\_\_

**ALLERGIES**

Aspirin  Penicillin

Barbiturates (Sleeping pills)  Sulfa

Codeine  Latex \_\_\_\_\_

Local Anesthetic  Other \_\_\_\_\_

**SIGNATURE**

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient

## STATEMENT OF PRIVACY PRACTICES

### HARBOUR POINTE 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.

# Harbour Pointe Family Dentistry

Acknowledgement of Receipt of Statement of Privacy Practices | Page 1 of 1

## 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 Harbour Pointe 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.

Harbour Pointe 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

OR

Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)  YES  NO

Any Member of my extended family: (i.e. Parents, Grandchildren)  YES  NO

OTHER:  YES  NO

Name of patient (please print):

Patient signature (if 18+ years of age):

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	



## RECORD RELEASE FORM

I, \_\_\_\_\_ request the release of dental records relevant to dental treatment, or copies of such, and request that they be transferred to:

We are requesting patients last **FMX and /or PANO** taken in the last 5 years.

**Patient Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

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**info@hpfdentistry.com**

phone 425-348-8484 fax 425-348-6419 **THANK YOU!!**