TOTEM LAKE DENTAL

ANDY TRINH, DDS
KATHERINE WANG, DDS

11811 NE 128th St, Suite A Kirkland WA 98034 | Phone: (425) 820-1820 | Fax: (425) 820-1829 | info@totemlakedental.com

Patient Information

Patient Name: _____ Preferred Name: _____
Last First MI

Soc. Sec. #: _____ Date of Birth: _____ ☐ Male ☐ Female

Address: _____

_____
City State Zip Code

Home Phone: _____ Cell Phone: _____

Email: _____ ☐ Married ☐ Single ☐ Child ☐ Other: _____

Employer Name: _____ Employer Phone #: _____ Occupation: _____

Please check: I would like to receive appointment reminders and billing correspondence by text

☐ Yes ☐ No

Referral Information

Whom may we thank for referring you to our practice? ☐ Internet ☐ Insurance ☐ Work ☐ Walk-By

☐ Another Patient: _____ Relation: _____

Emergency Contact

Name: _____ Cell Phone: _____ Relation: _____

Primary Insurance Information

Policyholder's Name: _____ Date of Birth: _____
Is the policyholder a patient? □ Yes □ No Patient's relationship: □ Self □ Spouse □ Child □ Other: _____
Insurance Company: _____ Inc Co. Phone #_____ Group #: _____
Group Name: _____ Member ID / Enrollee #: _____
Policyholder's Address: _____

Secondary Insurance Information

Policyholder's Name: _____ Date of Birth: _____
Is the policyholder a patient? □ Yes □ No Patient's relationship: □ Self □ Spouse □ Child □ Other: _____
Insurance Company: _____ Inc Co. Phone #_____ Group #: _____
Group Name: _____ Member ID / Enrollee #: _____
Policyholder's Address: _____

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Have you ever had any of the following? ☐ YES or ☐ NO **If yes, please check those that apply:

- ☐ AIDS/HIV Positive
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatism
- ☐ Shortness of breath
- ☐ Sinus Problems
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Surgical Implant
- ☐ Tobacco Habit
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ OTHER: _____

Medical History

Doctor's Name (Primary Care Provider): _____ Phone: _____

Have you had any serious illnesses or operations? ☐ Yes ☐No - Please describe: _____

Are you currently under physician care? ☐ Yes ☐ No - Please describe: _____

Are you currently taking any medication(s)? ☐ Yes ☐ No – Please list: _____

Do you have any known drug allergies? ☐ Yes ☐ No - Please list: _____

Women: Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control? ☐ Yes ☐ No

Dental History

What would you like us to do today? _____Are you in dental discomfort today? ☐ Yes ☐ No

How often do you brush? _____ Floss? _____ **Please check those that apply:** ☐Bleeding gums

☐Clicking/Popping Jaw ☐Food collection between teeth ☐Grinding/Clenching ☐Sensitivity to cold

☐Sensitivity to hot ☐Sensitivity to sweets ☐Bad breath

Former Dentist: _____ Phone #: _____

Date of last dental visit and service received: _____

Why did you leave the former dental office? _____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by Dr. Andy Trinh and Dr. Katherine Wang to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform Dr. Andy Trinh, Dr. Katherine Wang, or the staff. I authorize the insurance company indicated on this form to pay to Dr. Andy Trinh and Dr. Katherine Wang all insurance benefits otherwise payable to me for the services rendered. I authorize the use of this signature on all insurance submissions. I authorize Dr. Andy Trinh and Dr. Katherine Wang to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature of patient: _____ Date: _____ Print Patient Name: _____

Signature of responsible party: _____ Date: _____ Relationship to Patient: _____

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OFFICE POLICY

The following policies pertain to the office of Dr. Andy N. Trinh. Please read and sign below.

- SCHEDULING: A *Non-Refundable Scheduling Deposit Fee of $50 per hour will be collected upon scheduling an appointment longer than 2 hours.* The deposited amount will be applied toward the appointment
- PAYMENT: *Total payment is due at the time of service.* When using dental insurance, your portion will vary based on the procedure and plan coverage. *Treatment under $1,000 will be COLLECTED when treatment is rendered.* *If the estimated out of pocket for treatment is over $1,000, patients will be allowed the following payment plan: half down at start of treatment, and the remaining balance will be distributed into 3 monthly payments.
- ACCEPTED PAYMENTS: Visa, MasterCard, debit cards, checks and cash. We also offer payment plan options through Care Credit. *If a Financial Agreement has been authorized, payments are collected on the dates agreed upon. *A NSF Fee of $25 is automatically applied to any declined payments.*
- OUTSTANDING BALANCES: A statement will be emailed to you for any balance on your account. Balances over 30 days are subject to a service charge of 1% per month (12% annually). *All accounts that are 90 days past due will be referred to a collection agency.*
- DENTAL INSURANCE: Dental insurance is a contract between you, your employer, and the insurance company. Questions regarding your dental insurance coverage should be directed to your insurance company. As a courtesy, our office will verify your eligibility and coverage limitations. Please understand that phone verification is not a guarantee of benefits. Should your insurance company deny your claim, pay less than originally estimated or your benefits have been all used, you are responsible for the balance. Please keep us updated if you insurance coverage changes or you may be responsible for the entire appointment fee.
- INSURANCE CLAIMS: As a courtesy to our patients, we will submit your dental claim to the insurance company on your behalf.
- EMERGENCY TREATMENT: If we are not able to verify your insurance benefits prior to the emergency appointment, you (or responsible party) are responsible for all charges at the time of service. Once insurance is billed and when/if payment is received, we will refund any credit that may result.
- CANCELING/RESCHEDULING APPOINTMENTS: Your appointment time is reserved especially for you. If you are unable to keep your appointment or need to reschedule, please notify us at least 48 business hours prior to your appointment. Repeated cancellations or missed appointments will result in loss of future appointment privileges and possible dismissal from the practice.
- ARRIVAL TIME: Our grace period is 10 minutes. If you arrive later than 10 minutes after the scheduled appointment time, we may need to reschedule your appointment.

Appointments cancelled or changed with less than 48 business hours' notice will be subject to a non-refundable fee of $75 per hour of scheduled appointment time regardless of whether or not the appointment has been confirmed.

I have read, understood, and agree to the Office Policy of Totem Lake Dental.

_____	_____	_____
Patient and/or Guardian Signature	Patient Name - Print	Date

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ACKNOWLEGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices form the office of Totem Lake Dental (DBA). The Statement of Privacy Practices describes the types of uses and disclosures of my Protected Health Information (PHI) 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.

Totem Lake Dental (DBA) reserves the right to change the privacy practices currently described in the State 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 on 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 Protect Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO", without indication "YES" in answer to each individual question, protected health information (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)	□ YES	□ NO
Any Member of my extended family: (i.e. Siblings, Parents, Grandchildren)	□ YES	□ NO
Other (Name & Relation):		

Patient Name (Please Print): _____

Patient Signature: _____

Patient's Personal Representative (Please Print): _____

Representative's Phone Number: _____ Date: _____

OFFICE USE ONLY:	
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

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PATIENT NAME: _____ DATE OF BIRTH: _____

ADDRESS: _____

I authorize the release of records and/or x-rays from: _____
(Name of previous dental office)

Phone: _____ Fax: _____ E-mail: _____

TO: Totem Lake Dental Dr. Andy N. Trinh DDS 11811 NE 128th St. Suite A Kirkland WA 98034

Please e-mail digital records to: info@totemlakedental.com

Office Use:

Please Include Dental History Dates:

X-Rays:
FMX/PANO: _____ BWX: _____ PA's: _____

Exams:
Comp: _____ Periodic: _____ Limited: _____

Prophy: _____ **Perio Maintenance: _____**

UR SRP: _____ **LR SRP: _____**

UL SRP: _____ **LL SRP: _____**

Fillings done within 2 years (date, teeth #'s, and surface's) -- _____

Major Treatment (Crowns, Bridges, Dentures, or Implants) --_____

Ortho: START DATE - FINISH DATE: _____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE:_____

A PHOTOCOPY OF THIS AUTHORIZATION SHALL HAVE THE SAME EFFECT AS THE ORIGINAL