Patient Information

Confidential

Patient's Name: _____
First Middle Last

Address: _____
Street City State Zip

Birthdate: _____ Social Security No: _____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Check Appropriate box: ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Patient's or Parent's employer: _____ Work Phone: _____

Business Adress: _____ City: _____ State: _____ Zip: _____

Spouse or Parent's Name: _____ Employer: _____ Work Phone: _____

If patient is a Student, Name of School/ College: _____ City: _____ State: _____

Person to Contact in Case of an emergency: _____ Phone: _____

If patient is minor, give parent's or guardian's name: _____ ☐ Male ☐ Female

Relationship to patient: _____

Whom may we thank to referring you to our office? _Name: _____

Phone: _____ Updates: _____

RESPONSIBLE PARTY INFORMATION

Name: _____ Relationship to patient: _____
First Middle Last

Residence: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Insurance Information

Insured's Name: _____ Insured's Soc.Sec. No: _____

Insurance Company: _____ Group No. _____ Local No. _____

Insurance Co. Address: _____ Phone: _____

Is policy through an employer: _____ Employer's Name: _____

Do you have dual coverage? _____ Yes ___ No _____ If Yes: Which is primary? _____

Second insurance (dual coverage) _____

Insured's Name: _____ Insured's SS No. _____

Insurance Co. Group No. Local No. _____

Insurance Co. Address: _____ Phone: _____

Employer's Name

RESPONSIBITLY DISCLAIMER

I acknowledge that I am responsible for payment of all services rendered by Harchand Singh, DDS & Associates. I understand that, as a courtesy, their office will bill my insurance or me, but that I am ultimately responsible for my charges, regardless of what my dental insurance may or may not cover. I understand that where appropriate, credit bureau reports may be obtained.

Signature: _____ **Date:** _____

PATIENT MEDICAL HISTORY

Patients Name: _____ Date of Birth: _____

Physician: _____ Office Number: _____ Date of Last Exam: _____

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness?	☐	☐
3. Are you taking any medication(s), including non-prescription medicine? If yes, what medications are you taking? _____ _____	☐	☐
4. Do you use tobacco?	☐	☐
5. Do you use alcohol, cocaine, or other drugs?	☐	☐
6. Are you wearing contact lenses?	☐	☐

7. Are you allergic to or have any reactions to the following?

Yes	No		Yes	No		Yes	No	
☐	☐	Local Anesthetics	☐	☐	Barbiturates	☐	☐	Aspirin
☐	☐	Penicillin or Other Antibiotics	☐	☐	Sedatives	☐	☐	Other: _____ _____
☐	☐	Sulfa Drugs	☐	☐	Iodine			

WOMEN ONLY:

	Yes	No
a) Are you pregnant or think you may be pregnant?	☐	☐
b) Are you nursing?	☐	☐
c) Are you taking birth control pills?	☐	☐

8. Do you have any of the following?

Pharmacy NO: _____

Yes	No		Yes	No		YES	NO	
☐	☐	High Blood Pressure	☐	☐	heart disease	☐	☐	Chest Pain
☐	☐	Heart Attack	☐	☐	Cardiac Pacemaker	☐	☐	Easily Winded
☐	☐	Rheumatic Fever	☐	☐	Heart Murmur	☐	☐	Stroke
☐	☐	Swollen Ankles	☐	☐	Angina	☐	☐	Hay Fever/Allergies
☐	☐	Fainting/Seizures	☐	☐	Frequently Tired	☐	☐	Tuberculosis
☐	☐	Asthma	☐	☐	Anemia	☐	☐	Radiation Therapy
☐	☐	Low Blood Pressure	☐	☐	Emphysema	☐	☐	Glaucoma
☐	☐	Epilepsy/Convulsion	☐	☐	Cancer	☐	☐	Recent Weight Loss
☐	☐	Leukemia	☐	☐	Arthritis	☐	☐	Liver Disease
☐	☐	Diabetes	☐	☐	Joint Replacement or Implant	☐	☐	Heart Trouble
☐	☐	Kidney Diseases	☐	☐	Hepatitis/Jaundice	☐	☐	Respiratory Problem
☐	☐	Aids Or HIV infections	☐	☐	Sexually Transmitted Disease	☐	☐	Mental Illness/Depression
☐	☐	Other: _____						

Comments:

_____
_____
_____
_____
_____
_____
_____
_____
_____

PATIENT DENTAL HISTORY

	YES	NO
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Do you feel pain in your teeth?	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had any head, neck, or jaw injuries?	☐	☐
6. Do you clench or grind your teeth?	☐	☐
7. Have you ever had prolonged bleeding Following extractions?	☐	☐

8. Have you ever experience any of the following problems?

A) Clicking ☐

B) Pain (Joint, ear, side, or face) ☐

C) Difficulty in opening or closing ☐

D) Difficulty chewing ☐

* Do you have a fever, cough, sore throat, shortness of breath or any Covid related symptoms in the last 15 days? ☐ Yes ☐ No

Have you been fully vaccinated? ☐ Yes ☐ No

I certify that I had read and understood the above information to the best of my ability, the above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: _____ **DATE:** _____

ACKNOWLEDGMENT
OF
PRIVACY PRACTICES

Tukwila Dental Center
13955 Interurban Avenue So.,
Tukwila, WA 98168
Tel No: (206) 431-0953 FAX No: (206) 439-6860

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 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 and 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 Practice* 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 many private information is used to 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 Offices Use Only:

We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency
- Other

SPECIAL CONSENT AND RELEASE FORM FOR TREATMENT

I hereby authorize Harchand Singh, DDS PS, Associates, and Assistants as may be designed to perform all needed dental procedures and any other form of treatment, including appropriate anesthesia, they may deem necessary for the welfare and treatment of:

Name of Patient: _____

I consent to the dental examination, x-rays, consultation, and treatment by Dr. Singh, Associates, and Assistants.

I understand that the expected results of said treatment cannot always be guaranteed. If I desire, I can discuss, to my satisfaction, the following:

- The nature and character of the proposal treatment
- The anticipated results of the prosed treatment
- The recognized alternative forms of treatment
- The recognized serious possible risks and complications of the treatment and of the recognized alternative forms of the treatment, including non- treatment.
- The anticipated date and time of the proposed treatment

I understand that I am free to withhold or withdraw consent to the proposed treatment at any time.

Witness: _____ Signature of person giving consent: _____

Date signed: _____ Time: _____ Relationship to patient (if applicable) _____

Are there any questions about the procedures, risks, etc.?

( ) Yes ( )No

No treatment will be performed until this consent has been executed. This will be permanently filed in the patient's dental record.

Harchand Singh, D.D.S P. S and Associates

FINANCIAL POLICY

Effective January 2018

Thank you for choosing Tukwila Dental Center as your healthcare provider. We are committed to proving the best dental care possible. Please understand that payment of your bill is considered as part of your treatment. The following statement explains our Financial Policy which we ask you to read, sign and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service or upon receipt of invoice.
- We accept cash, check, or credit cards.

Regarding Insurance

We participate in **most** insurance plan: however, we require the guarantor, the person who is financially responsible, is personally liable for all balance not covered by insurance. It is your responsibility to understand and comply with any Pre-determination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services our may not be considered medically necessary under the Medicaid program or by other medical insurance companies.

We will file all insurance claims with the insurance provider you supply our office with. Please be sure to update our office of any changes in your insurance. Please also remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. Your insurance company may need you to supply certain information directly in order to pay the claim.

If you are uncertain about your current insurance policy benefits you should contact your plan to learn the details about your benefits, out -of-pocket expenses and, coverage limits.

Initials: _____

Cost of Treatment

Treatment plans are customized for individual care. To that end we want you to be aware of your financial investment into your care and do so by providing estimates of your out-of- pocket expenses based upon your plan. Please understand that any estimate given is just an estimation of costs as there are many factors that contribute to the treatment and insurance coverage.

Initials: _____

Missed Appointments

Tukwila Dental Center requires 24- hour notice of appointment cancellation. Appointment missed and are not previously cancelled will be charged a fee of $50.00.

Minors

The parent(s), guardian(s), or Financial Guarantor is responsible for full payment and will receive the billing statement. A signed release to treatment may be required for unaccompanied minors.

Past Due Accounts

I/We agree to pay all attorneys fees, court cost, and filing fees, which may be assessed by any collection agency or law firm retained to pursue the matter. Additionally, past due balances shall accrue interest at the rate of 1.5% percent per month.

Initials: _____

Accounting Principals

Payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding services.

Address Changes

It is our policy to provide invoices for any amounts owed on your account. We send all correspondence to the address information you provide, so please advise us anytime there is a change to your address, telephone number or other contact information.

Retuned Checks

For checks returned to us as unpaid by your bank, we will charge a $25.00 fee. Please contact our office if you have any questions of concerns at (206)- 431-0953.

I authorize Tukwila Dental Center to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim. I authorize my insurance benefits to be paid directly to Tukwila Dental Center.

I have read the Financial Policy. I understand and agree to the Financial Policy.

_____ _____

Financial Guarantor- Print name Email Address

_____ _____ _____

Signature Date Cell Phone