Paul A. Sioda, DDS
1919 North Pearl Street, Suite A5
Tacoma, Washington 98406
253-759-7941

HEALTH HISTORY

Today's Date: _____/_____/_____
Patient Name: _____
Last First MI
What You Prefer to be Called: _____ ☐ Male ☐ Female
Birthdate: ___/___/___ Age: _____ SS#:_____

Mailing Address: _____

_____
City State Zip

Home Phone: (_____)_____

(_____)_____ EXT ____ (_____)_____
Work Phone Cell Phone
E-mail Address: _____

Referred by: _____

Employer: _____ Occupation: _____

Status: ☐ Minor ☐ Single ☐ Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: _____

Do you have children? ☐ Yes ☐ No How Many? _____

Person ultimately responsible for account:
Name: _____

Relation: _____

Billing Address: _____

_____
City State Zip

SS#: _____ Driver's License#: _____

Payment Method: ☐ Cash ☐ Check ☐ Visa/MasterCard

_____ I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company

Primary Dental Insurance
Company Name: _____

Mailing Address: _____

_____
City State Zip

Phone #: (_____)_____

Insured ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/_____

Insured's Employer: _____

Secondary Dental Insurance
Company Name: _____

Mailing Address: _____

_____
City State Zip

Phone #: (_____)_____

Insured ID#: _____

Group #: _____

Insured's Name: _____

Relation: _____ Date of Birth: ___/___/_____

Insured's Employer: _____

Emergency Contact: _____ Relation: _____

Phone #: _____ Cell Phone #: _____

Medical Doctor: _____Phone #: _____

Patient name: _____ Date: _____

Reason for today's visit: □ Exam □ Emergency □Consultation Are you in pain? □ No □ Yes How long? _____
Please indicate any of the following problems:
□ Discomfort, clicking, or popping in jaw □ Lost/broken filling(s) □ Stained Teeth □ Red, swollen, or bleeding gums
□ Teeth grinding □ Locking jaw □ Sensitive tooth, teeth, or gums □ Ringing in ears □ Bad breath
□ Blisters/sores in or around the mouth □ Broken/chipped tooth □ Other: _____
Do you require pre-medication? □ Yes □ No □ Don't know
Previous Dentist: _____ Phone #: (_____) _____ Last dental exam: ____/____/____
Last dental x-rays: ____/____/____ Times/day you brush: _____ Time/day you floss: _____
What type of tooth brush do you use? □ Soft □ Medium □ Hard
How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

What medications are you taking? □ Nerve pills □ Pain killers (including aspirin) □ Muscle relaxers □ Stimulants
□ Blood Thinners □ Tranquilizers □ Insulin □Meds for Osteoporosis □Other(s), please list:

_____

Have you ever taken: Bisphosphonates (ex: Aredia/Fosamax) □ Yes □ No Phen-fen/Redux □ Yes □ No
Have you ever had Botox or fillers? □ Yes □ No If yes: when, where, what type? _____
Do you have or have you had any of the following diseases, medical conditions, or procedures?

Y N Heart attack/stroke	Y N Frequent Headaches	Y N Cancer/tumors	Y N Cosmetic surgery
Y N Heart surgery/pacemaker	Y N Kidney Problems	Y N Shingles	Y N Xray treatment
Y N Heart murmur	Y N Liver Problems	Y N Hepatitis	Y N Chemotherapy
Y N Rheumatic Fever	Y N Respiratory Problems	Y N HIV+/AIDS/ARC	Y N Asthma
Y N Mitral valve prolapse	Y N Sinus Problems	Y N Arthritis/Rheumatism	Y N Difficulty Breathing
Y N Artificial valves	Y N Stomach Problems/Ulcers	Y N Artificial bones/joints	Y N Diabetes
Y N Heart disease	Y N Thyroid Problems	Y N Emphysema	Y N Leukemia
Y N Congenital heart defect	Y N Alcohol/Drug abuse	Y N Fainting/Seizures/Epilepsy	Y N Anemia
Y N Chest Pains	Y N Psychiatric problems	Y N Low Blood Pressure	Y N High Blood Pressure
Y N Scarlet Fever	Y N Tuberculosis TB	Y N Frequent Neck Pain	Y N Bleeding Problems
Y N Nervousness	Y N Jaw Problems TMJ/TMD	Y N Back Problems	Y N Glaucoma

Please list any other surgeries or medical conditions you have ever had: _____

_____

Are you allergic to any of the following? □ Latex □ Penicillin / Amoxicillin □ Tetracycline □ Aspirin
□ Dental Anesthetics □ Foods: _____ □ Others: _____

Do you use tobacco? □ No □ Yes How used? _____ How much? _____ How long? _____
Please rate your general health from 1-10: _____ Do you wear contact lenses? □ Yes □ No
For women: Are you taking birth control pills? □ Yes □ No How many children have you had? _____
Are you pregnant? □ No □ Yes How long? Are you nursing? □ Yes □ No

- We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual, understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of services and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services during diagnosis and treatment. I also authorize provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: _____ □ Adult Patient □ Parent or Guardian □ Spouse Date: _____/_____/_____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

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 (HIPPA). 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 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. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Date: _____

Signature: _____
If minor, Parent or Guardian's Signature

Dependent family members also covered by this acknowledgement:

_____

For Office Use Only:

We are 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 situation
□ Other

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OFFICE FINANCIAL POLICY

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these options for payments:

- Visa or MasterCard
- Payment by appointment
- Payment plan

We are committed to supporting you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solution possible to treat your personal situation.

We will, as a courtesy, process your insurance benefits in our office. Dental benefit plans can vary from company to company, with different procedures covered and not covered. Insurance companies base the amounts that they will pay toward your treatment on restricted fee schedules related to the premium payments and geographical location. Each insurance company has a set fee for each service, regardless of what the actual fee might be. Deductibles and co-payments are typically built into insurance plans and state laws enforce payments of these co-payments. If you have insurance, we ask that you pay the portion of your treatment not covered by insurance, along with the deductible; at the time treatment is rendered. We will estimate the patient portion for you at each appointment; however, we make no guarantee of any estimated coverage. We are happy to submit your insurance as a service to you, but it is your responsibility to keep us updated of any insurance changes and to make sure the charges we submit do not exceed your maximum benefit. We can also, as a courtesy, submit a pre-determination to your insurance company to determine eligibility and whether the treatment is covered under the plan. As defined by the insurance company, a pre-determination does not guarantee benefits. If your insurance company does not pay, the outstanding balance will be your responsibility, regardless of the estimate given. All questions regarding your insurance benefits must be addressed to your insurance carrier.

Financial Agreement:
I agree that I am fully responsible for the total payment of all procedures performed in this office – this indicates any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at the time of service for all services rendered. I understand that all services are to be paid within sixty (60) days following the date of the procedure preformed, regardless of whether or not my insurance benefits have been received. One and a half percent (1.5%) per month interest and eighteen percent (18%) per year interest (per RCW 19.52) will be charged on accounts sixty days from treatment date.

I assign directly to Dr. Paul Sioda, DDS all insurance benefits, if any, otherwise payable to me for services rendered. Dr. Paul Sioda, DDS may use my dental health care information and may disclose such information to my insurance company and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience.

_____

Signature, if minor, Parent or Guardian's Signature Name Date

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CONSENT FOR INTERNET COMMUNICATIONS

1. RISK OF USING E-MAIL

Paul Sioda, DDS (the "Practice") offers patients the opportunity to communicate by e-mail. Transmitting patient information by e-mail, however, has a number of risks that patients should consider before using e-mail (the "Risks"). These include, by are not limited to, the following Risks:

a) E-mail can be circulated, forwarded, and stored in numerous paper and electronic files.
b) E-mail can be immediately broadcast worldwide and be received by any intended and unintended recipients.
c) E-mail senders can easily misaddress an e-mail.
d) E-mail is easier to falsify than handwritten or signed documents.
e) Back-up copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.
f) Employers and on-line services have a right to archive and inspect e-mails through their systems.
g) E-mail can be intercepted, altered, forwarded, or used without authorization or detection.
h) E-mail can be used to introduce viruses into computer systems.
i) E-mail can be used as evidence in court.

2. CONDITIONS FOR THE USE OF E-MAIL

The Practice will use reasonable means to protect the security and confidentially of e-mail information sent and received. However, because of the Risks outlined above, the Practice cannot guarantee the security and confidentiality of e-mail communication, and will not be liable for improper use and/or disclosure of confidential information (including Protected Health Information that is the subject of the federal Heath Insurance Portability and Accountability Act of 1996) that is not caused by the Practice's intentional misconduct. Thus, patients must consent to the use of e-mail for patient information. Consent of the use of e-mail include agreement with the following conditions:

a) All e-mails to or from the patient concerning diagnosis or treatment will be printed out and made part of the patient's record. Because they are a part of the dental record, other individuals authorized to access the dental record, such as staff or billing personnel, will have access to those e-mails.
b) The Practice may forward e-mails internally to the Practice's staff as necessary for diagnosis, treatment, reimbursement, and other handling. The Practice will not forward e-mails to independent third parties without the patient's prior written consent, except as authorized or required by law.
c) Although the Practice will endeavor to read and respond promptly to an e-mail from the patient, the Practice cannot guarantee that any particular e-mail will be read and responded to within any particular period of time. Thus, the patient shall not use e-mail for dental emergencies or other time-sensitive matters.
d) If the patient's e-mail requires or invites a response from the Practice, and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the e-mail and when the recipient will respond.
e) The patient is responsible for informing the Practice of any types of information the patient does not want to be sent by e-mail.
f) The patient is responsible for protecting his/her password or other means of access to e-mail. The Practice is not liable for breaches of confidentiality caused by the patient or any third party.
g) It is the patient's responsibility to follow up and/or schedule an appointment if warranted.

3. INSTRUCTIONS

To communicate to e-mail, the patient shall:

a) Inform the Practice of changes in his/her e-mail address.
b) Take precautions to preserve the confidentiality of e-mails, such as safeguarding passwords.
c) Withdraw consent only by written communication to the Practice.

4. PATIENT ACKNOWLEDGMENT AND AGREEMENT

I acknowledge that I have read and fully understand the information the Practice has provided me regarding the Risks of using e-mail. I understand the Risks associated with the communication of e-mail between the Practice and me, and consent to the Conditions outlined above. In addition, I agree to the Instructions outlined previously, as well as any other Instructions that the Practice may impose regarding e-mail communication.

_____

Printed patient name | Signature of patient, if minor, guardian | E-mail address | Date