Seattle Choice Dental
Dr. Cho, DDS
9714 3rd Ave., Suite 200
Seattle, WA 98115
O (206)523-7600 F (206)524-2711

PATIENT REGISTRATION

Welcome to our office. We appreciate the confidence you place in us to provide quality dental care. To assist us in serving you, please complete the following form. All information is kept strictly confidential.

PLEASE PRINT Date_____

Who may we thank for referring you to our office? _____

Last Name_____ First Name_____ Middle_____

Preferred Name_____ Date of Birth_____ Sex:M/F Other_____

Pronouns _____

Child'Name_____ Date of Birth _____

Preferred Name_____ Sex: M/F Other _____ Pronouns _____

Address_____ Apt # _____

City_____ State _____ Zip_____

Billing Address _____

City_____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Preferred Contact Method_____ SS#_____

Employer _____

Occupation _____ Full or Part-time _____

Name of Spouse _____ Date of Birth_____

Spouse's Employer _____ Spouse's Phone _____

Emergency Contact and Phone _____

Preferred Pharmacy Info _____

Family Members Who Are Patients Here _____

RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address_____ Apt #_____

City_____ State _____ Zip_____

Phone _____ Employer_____

PRIMARY INSURANCE INFORMATION

Policy Holder (Subscriber) _____

SS#_____ Relationship to Patient: O Self O Spouse O Child O Other

Date of Birth _____Employer _____

Dental Insurance Company _____

Policy #/Group #/Patient ID # _____

SECONDARY INSURANCE INFORMATION

Policy Holder (Subscriber) _____

SS#_____ Relationship to Patient: O Self O Spouse O Child O Other

Date of Birth _____Employer_____

Dental Insurance Company _____

Policy #/Group #/Patient ID # _____

I have completed this form completely to the best of my knowledge and certify that I am the patient or agent of the patient authorized to furnish the information requested. I understand that although I may have some type of dental insurance coverage, I am responsible for payment of services.

Signature _____ Date _____

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HEALTH HISTORY

Although our dental team primarily treats the area in and around your mouth, it is important for us to know about your overall health. Medical conditions or medications that you may be taking could have an important relationship with the dentistry you receive. Thank you for answering the following questions. All information is kept strictly confidential.

DENTAL HEALTH HISTORY

Name_____

Previous dentist_____ City_____

How long _____ Date of last checkup and cleaning_____

Reason for today's visit _____

How often do you brush? _____ Floss? _____ See a dentist? _____

What, if anything, would you change about your teeth? _____

Do you wear a nightguard? _____ Are you a habitual gum or ice chewer? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Anxiety about dental treatment	O	O	Orofacial (mouth/face) pain	O	O
Problems with past dental treatment	O	O	Head/Neck injury or radiation	O	O
Wear dentures	O	O	Lip/mouth sores that are slow to heal	O	O
Difficulty chewing your food	O	O	Problems after a tooth extraction	O	O
Bleeding gums	O	O	Periodontal Disease	O	O
Sore or sensitive teeth	O	O	Deep cleaning (root planing)	O	O
Grind or clench your teeth	O	O	Periodontal Treatment (gum grafts)	O	O

	YES	NO		YES	NO
Difficulty opening	O	O	Oral Surgery	O	O
Temporomandibular disorder (TMD)	O	O	Orthodontic Treatment	O	O

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MEDICAL HISTORY

Physician's name _____ Type _____ How long? ____

Office Address _____ Phone _____

Please list all medications that you currently take _____

_____

_____

Do you require premedication (antibiotics) before dental treatment? _____

If yes, what? _____

Do you use tobacco or smoke?_____ If so, what type_____

How much? _____ How long? _____

Do you use cannabis?___ Yes ___ No How often? _____

Do you consume alcohol? _____ If so, how much?_____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Hospitalization for illness or surgery	O	O	Blood transfusion	O	O
Heart trouble/disease	O	O	Ulcers	O	O
Heart attack or failure	O	O	Significant weight gain or loss	O	O
Chest pains	O	O	Special diet	O	O
Shortness of breath	O	O	Intestinal problems	O	O
Heart valve problems/artificial valve	O	O	Kidney disease or bladder problems	O	O
Heart murmur	O	O	Arthritis	O	O
Rheumatic fever	O	O	Back or neck pain	O	O
Pacemaker	O	O	Joint replacement/pin placement	O	O
High blood pressure	O	O	Fainting spells, seizures, or epilepsy	O	O
Low blood pressure	O	O	Frequent or severe headaches	O	O
Stroke	O	O	Thyroid or parathyroid disorders	O	O
Easy bruising	O	O	Persistent cough or swollen glands	O	O

Abnormal bleeding	O	O	Hepatitis (indicate type)	O	O
Anemia or other blood disorders	O	O	Jaundice	O	O
Liver disease	O	O	Sinus problems	O	O
Diabetes	O	O	Emphysema	O	O
Frequent urination	O	O	Emotional problems or tension	O	O
Frequent thirst or dry mouth	O	O	Psychiatric treatment	O	O
Taken Phen-Fen	O	O	History of alcohol or drug abuse	O	O
Tuberculosis	O	O	History of head injury	O	O

Scarlet Fever	O	O	Cancer or Tumor	O	O
Glaucoma	O	O	Radiation treatment	O	O
Wear contact lenses	O	O	Prostate disorders (if male)	O	O
Asthma	O	O	HIV positive	O	O
Hives, skin rash, hay fever	O	O	AIDS	O	O

ARE YOU ALLERGIC OR REACTED ADVERSELY TO ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Local Anesthetics ("novocaine")	O	O	Metal	O	O
Penicillin or other antibiotics	O	O	Latex	O	O
Sulfa drugs	O	O	Aspirin	O	O
Tetracycline	O	O	Acetaminophen	O	O
Sedatives or sleeping pills	O	O	Ibuprofen	O	O
Codeine or other narcotic	O	O	Any other medication	O	O

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF THE FOLLOWING:

	YES	NO		YES	NO
Antibiotics or sulfa drugs	O	O	Anticoagulants (e.g., coumadin)	O	O
High Blood Pressure Medication	O	O	Tranquilizers	O	O
Insulin, Orinase, or similar	O	O	Aspirin	O	O
Digitalis or other heart medication	O	O	Nitroglycerin	O	O

	YES	NO		YES	NO
Cortisone or other steroids	O	O	Natural remedies	O	O
Vitamin Supplements	O	O	Nonprescription drugs	O	O

WOMEN:

	YES	NO		YES	NO
Are you pregnant	O	O	Taking oral contraceptives	O	O
Nursing	O	O	Reached Menopause	O	O

Do you have any disease, condition, or problem not listed previously that we should know about? If so, please describe in detail _____

_____

_____

To the best of my knowledge, the questions on this form have been adequately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental staff of any changes in my health history.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN

_____ DATE _____

DENTAL STAFF INITIALS _____ DATE _____

DENTIST'S INITIALS _____ DATE _____

PATIENT FINANCIAL POLICY

In the interest of good communication and our commitment to provide the highest quality of dental care available, we have established a Patient Financial Policy. It is our hope this policy will facilitate open communication between us and help avoid potential misunderstandings.
As a courtesy, we try to provide an accurate as possible ESTIMATE for your dental work based on the information provided by your insurance company. Any actual insurance benefit is not guaranteed as they are subject to review by your insurance company.

For treatment covered by insurance, we will ask for payment of the portion of fees not covered by insurance at the time of your procedure.

METHODS OF PAYMENT:
Acceptable methods of payment are, check, Visa, Mastercard, American Express, Discover, or debit cards.

INSURANCE:
As a courtesy, we will bill your insurance company if provided with all the proper billing information. Insurance is a contract between you and your insurance company. Although we will do the best of our ability to estimate what your insurance company may pay, it is the insurance company that makes the final determination of eligibility. Account balances are due within 60 days, regardless of insurance involvement. A .75% monthly finance charge will be assessed on all accounts past 60 days.

MONTHLY STATEMENTS:
If there is a balance owing on your account, we will send you a monthly billing statement. It will show separately a previous balance along with any new charges or payments made to your account. In the event that your account has a credit balance, we generally issue refunds to the appropriate party within two weeks of the payment which created the credit.

RETURNED CHECKS:
There is a $30.00 fee for any checks returned by the bank.

MISSED APPOINTMENT:
Patients who do not show up for an appointment or cancel with less than 48 business hours notice will be charged a $50 cancellation fee per hour depending upon the circumstances.

PAST DUE ACCOUNTS:
If your account becomes past due, we will take the necessary steps to collect the debt. Exceptionally delinquent accounts will be sent to collections. We appreciate your effort to keep your account current. Unpaid balances are subject to a $25 fee.

Please feel free to ask any questions you may have regarding these policies. We are most willing to help you in any way we can.

Signature (responsible party) Date

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MY 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 information used or 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 law, 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 record for the purposes of treatment, payment and health care operations.

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. For example, we may need to share information with other health care providers or specialists involved in the continuation of your care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection, and utilization review. For example, we may 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, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. 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 may exercise by presenting a written request to our Privacy Officer at the practice address listed below:

- 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 a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.

- The right to request 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, with limited exceptions. A reasonable fee may apply.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operation, or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

We are required by law to maintain the privacy of your 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 January 1, 2007 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 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.

You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices, please contact:

Hyomi Cho, DDS ~ 9714 3rd Ave NE, Suite 200, Seattle, WA 98115 ~ (206) 523-7600

Acknowledgment of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of Dr. Hyomi Cho. 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 healthcare 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.

Dr. Hyomi Cho reserves the right to change the privacy practices that are 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 to me.

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 persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐	**YES**	☐	**NO**
SPOUSE ONLY	☐	**YES**	☐	**NO**
OTHER (***PLEASE SPECIFY***):	☐	**YES**	☐	**NO**

Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____

Description of Personal Representative's Authority:_____. Date:_____

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement not obtained		
PROVIDED PRIOR TO TREATMENT?	☐ **YES** ☐ **NO**	
DATE PROVIDED:		
REASON FOR DENIAL:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.
	☐	UNABLE TO SIGN.
	☐	REASON NOT GIVEN.
	☐	OTHER (EXPLAIN):