



## Acknowledgment of Privacy Practices & Patient Consent Form

Costa & Dageenakis Family Dentistry  
 1565 Woodridge Dr SE, Port Orchard, WA 98366  
 (360) 876-0550

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 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 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 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 of 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: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature \_\_\_\_\_  
 Dependent family members also covered by this acknowledgement: \_\_\_\_\_

### Authorization to Release Information to Others

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your condition and/or treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

- You May Disclose My Information To The Following  
 Do Not Disclose My Information to Anyone But Me

Name \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Name \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

**For Office 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 Situation \_\_\_\_\_ Other \_\_\_\_\_

Marta R. Costa, D.D.S.  
 Miranda S. Dageenakis, D.D.S.

## OFFICE FINANCIAL POLICIES

The following financial policies have been prepared to better prepare you for your dental treatment and to help eliminate any confusion regarding necessary payments. Please read thoroughly and feel free to ask any questions.

1. An estimate of fees for any treatment is available upon request.
2. You are fully responsible for all charges. If you have insurance, we will submit it for you as a courtesy. In many cases we can estimate closely what your patient portion will be and payment of that amount is expected at the time of service.  
**UNFORTUNATELY, WE CANNOT GUARANTEE ANYTHING YOUR INSURANCE COMPANY SAYS REGARDING ELIGIBILITY OR BENEFITS, BUT WILL TRY TO HELP IN CASE YOU HAVE A DISPUTE WITH THEM. WE ARE NOT RESPONSIBLE FOR INSURANCE NON-PAYMENT OR UNDERPAYMENT FOR ANY REASON. YOU REMAIN PRIMARILY RESPONSIBLE FOR PAYMENT.**
3. Payment is expected at the time of service.  
**IF YOU HAVE INSURANCE, WE REQUEST THAT YOU PAY YOUR ESTIMATED PORTION AT THE TIME SERVICES ARE RENDERED.**
4. At least half of the fee for dental treatment that is considered major, (crowns, bridges, dentures, partial dentures & root canals) must be paid when the procedure is begun and the final payment made at the insertion appointment.
5. We accept cash, checks, Visa and MasterCard.
6. Any outstanding balances exceeding 60 days receive a 1% per month service charge. Outstanding balances exceeding 90 days will be charged a \$15.00 late fee per month there after.
7. NSF checks will result in a \$40.00 Charge.
8. Please ask whenever you have any questions regarding your treatment charges. We will be glad to answer any of your questions.
9. **We reserve the right to charge a missed/cancelled appointment fee of \$40.00 per hour for appointments with less than 24 hours notice.**

**I HAVE READ AND ACCEPT THE FINANCIAL POLICIES AS EXPLAINED ABOVE.**

\_\_\_\_\_  
Patient (Print)

\_\_\_\_\_  
Patient  
Parent or Guardian if Minor  
(Signature)

\_\_\_\_\_  
Date

# Thank You for Selecting Our Dental Team

To help us meet all your healthcare needs, please fill out this form completely in ink.  
If you have any questions or need assistance, please ask us and we will be happy to help.

## Patient Information (Confidential)

Patient Number \_\_\_\_\_

Name \_\_\_\_\_ Date \_\_\_\_\_

SS#/SIN \_\_\_\_\_ Birthdate \_\_\_\_\_ Home Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Cell Phone \_\_\_\_\_

Email \_\_\_\_\_

Check Appropriate Box:  Minor  Single  Married  Separated  Divorced  Widowed

If Student, Name of School/College \_\_\_\_\_ City \_\_\_\_\_ State/Prov. \_\_\_\_\_  Full Time  Part Time

Patient or Parent/Guardian's Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Work Phone \_\_\_\_\_

Spouse or Parent/Guardian's Name \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_

Whom May We Thank for Referring You? \_\_\_\_\_

Person to Contact in Case of Emergency \_\_\_\_\_ Phone \_\_\_\_\_

## Responsible Party

Name of Person Responsible for this Account \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Email \_\_\_\_\_ Cell Phone \_\_\_\_\_

Driver's License # \_\_\_\_\_ Birthdate \_\_\_\_\_ Financial Institution \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone \_\_\_\_\_ SS#/SIN \_\_\_\_\_

Is this Person Currently a Patient in our Office?  Yes  No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash  Personal Check  Credit Card  VISA  MasterCard  I wish to discuss the office's payment policy.

## Insurance Information

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Do You Have Any Additional Insurance?  Yes  No If Yes, Complete the Following

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Birthdate \_\_\_\_\_ SS#/SIN \_\_\_\_\_ Date Employed \_\_\_\_\_

Name of Employer \_\_\_\_\_ Union or Local # \_\_\_\_\_ Work Phone \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group # \_\_\_\_\_ Policy/ID# \_\_\_\_\_  
State/Prov. \_\_\_\_\_ Zip/P.C. \_\_\_\_\_

Ins. Co. Address \_\_\_\_\_ City \_\_\_\_\_

How Much is Your Deductible? \_\_\_\_\_ How Much Have You Used? \_\_\_\_\_ Max. Annual Benefit \_\_\_\_\_

Over Please

# Patient Medical History

Physician \_\_\_\_\_ Office Phone \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

	Yes	No		Yes	No
1. Are you under medical treatment now?	<input type="checkbox"/>	<input type="checkbox"/>	10. Are you wearing contact lenses?	<input type="checkbox"/>	<input type="checkbox"/>
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	<input type="checkbox"/>	<input type="checkbox"/>	11. Are you allergic to or have you had any reactions to the following?		
If yes, please explain _____			Local Anesthetics (e.g. Novocain)	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you taking any medication(s) including over-the-counter medicine?	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin or any other Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what medication(s) are you taking? _____			Sulfa Drugs	<input type="checkbox"/>	<input type="checkbox"/>
4. Have you ever taken Fen-Phen/Redux?	<input type="checkbox"/>	<input type="checkbox"/>	Barbiturates	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever taken Fosamax, Boniva, Actonel or any cancer medications containing bisphosphonates?	<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you taken Viagra, Revatio, Cialis or Levitra in the last 24 hours?	<input type="checkbox"/>	<input type="checkbox"/>	Iodine	<input type="checkbox"/>	<input type="checkbox"/>
7. Do you use tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you use controlled substances?	<input type="checkbox"/>	<input type="checkbox"/>	Any Metals (e.g. nickel, mercury, etc.)	<input type="checkbox"/>	<input type="checkbox"/>
9. Do you have or have you had any of the following?			Latex Rubber	<input type="checkbox"/>	<input type="checkbox"/>
			Other _____	<input type="checkbox"/>	<input type="checkbox"/>
			12. Do you have a persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)?	<input type="checkbox"/>	<input type="checkbox"/>
			13. Women Only:		
			Are you pregnant or think you may be pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you nursing?	<input type="checkbox"/>	<input type="checkbox"/>
			Are you taking oral contraceptives?	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No		Yes	No		Yes	No
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Chest Pains	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Cardiac Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Swollen Ankles	<input type="checkbox"/>	<input type="checkbox"/>	Angina	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>
Fainting/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Frequently Tired	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/>	<input type="checkbox"/>
Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>
Fits/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Recent Weight Loss	<input type="checkbox"/>	<input type="checkbox"/>
Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement or Implant	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Diseases	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory Problems	<input type="checkbox"/>	<input type="checkbox"/>
AIDS or HIV Infection	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Problem	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Troubles/Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Other _____	<input type="checkbox"/>	<input type="checkbox"/>

# Patient Dental History

Name of Previous Dentist \_\_\_\_\_ Date of Last Exam \_\_\_\_\_

Previous Dentist's Location \_\_\_\_\_ Date of Last Cleaning \_\_\_\_\_

	Yes	No		Yes	No
1. Do your gums bleed while brushing or flossing?	<input type="checkbox"/>	<input type="checkbox"/>	8. Do you have frequent headaches?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are your teeth sensitive to hot or cold liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	9. Do you clench or grind your teeth?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are your teeth sensitive to sweet or sour liquids/foods?	<input type="checkbox"/>	<input type="checkbox"/>	10. Do you bite your lips or cheeks frequently?	<input type="checkbox"/>	<input type="checkbox"/>
4. Do you feel pain to any of your teeth?	<input type="checkbox"/>	<input type="checkbox"/>	11. Have you ever had any difficult extractions in the past?	<input type="checkbox"/>	<input type="checkbox"/>
5. Do you have any sores or lumps in or near your mouth?	<input type="checkbox"/>	<input type="checkbox"/>	12. Have you ever had any prolonged bleeding following extractions?	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you had any head, neck or jaw injuries?	<input type="checkbox"/>	<input type="checkbox"/>	13. Have you had any orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever experienced any of the following problems in your jaw?			14. Do you wear dentures or partials?	<input type="checkbox"/>	<input type="checkbox"/>
Clicking	<input type="checkbox"/>	<input type="checkbox"/>	If yes, date of placement _____		
Pain (joint, ear, side of face)	<input type="checkbox"/>	<input type="checkbox"/>	15. Have you ever received oral hygiene instructions regarding the care of your teeth and gums?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in opening or closing	<input type="checkbox"/>	<input type="checkbox"/>	16. Do you like your smile?	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty in chewing	<input type="checkbox"/>	<input type="checkbox"/>			

## Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance

company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X

Signature of patient (or parent/guardian if minor)

Doctor's Comments _____	
Signature _____	Date _____