WELCOME

Welcome to our office! We are delighted to have you as a new patient and we thank you for placing your confidence in us.

Our office is a provider of optimal dental care and patient education. We are dedicated to providing you and your family with the highest quality dental care. It will be our pleasure to help you achieve the most healthy, attractive and comfortable dental health possible.

If you have dental insurance, we are happy to bill it as a courtesy; however, your insurance is a contract between you, your employer, and the insurance company. Your portion will be due at the time of service unless other arrangements are made.

For your convenience we have early morning and late afternoon appointments available: Monday and Tuesday 10:00 AM to 6:00 PM, Wednesday and Thursday 7:30 AM to 3:00 PM. Appointments are difficult to reschedule, so please make them a priority. If you are unable to keep an appointment, we ask that you give us at least 48-hour's notice.

Thank you for choosing our office for your dental needs, and we look forward to your visit.

Sincerely,

Dr. Kristine Aadland, Dr. Melany Mallett and Staff

A: 117 E 39th Street, Vancouver, WA 98663 P: (360)694-7931
E: info@westvancouverdental.com W: www.westvancouverdental.com

PATIENT REGISTRATION INFORMATION

Welcome to our office. We appreciate the confidence you place with us to provide dental services. To assist us in serving you, please complete the following form. The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us. If you have any questions, don't hesitate to ask.

Patient name: _____ *How do you prefer to be addressed?* _____

Date of birth: _____ *Sex:* _____ *Age:* _____ *Referred to us by:* _____

Home address: _____ *City:* _____ *State:* _____ *Zip:* _____

Billing address (if different): _____ *City:* _____ *State:* _____ *Zip:* _____

Home phone: _____ *Cell:* _____ *Bus. Phone:* _____ *Email:* _____

Driver's license #: _____ *State:* _____ *SS #:* _____

Employer: _____ *Occupation:* _____

Spouse/Partner Name: _____ *contact #:* _____

Emergency contact & phone# (other than spouse/partner) _____

***Primary** dental insurance:* _____ *Member ID #:* _____

Subscribers name: _____ *Subscribers birth date* _____ *Gp#* _____

***Secondary** dental insurance:* _____ *Member ID #:* _____

Subscribers name: _____ *Subscribers birth date* _____ *Gp#* _____

Name of your medical doctor: _____ *Date of last visit to medical doctor:* _____

Name of previous dentist: _____ *Date of last visit to dentist:* _____

MEDICAL HEALTH HISTORY

Do you have or have you ever had

Heart Trouble	Y/N	Swelling of Feet/ Ankles, Hands	Y/N	Tuberculosis	Y/N	Pain in Jaw Joints	Y/N
Heart Surgery	Y/N	Fainting or Dizziness	Y/N	Frequent Cough	Y/N	Glaucoma	Y/N
Artificial Heart Valve	Y/N	Stroke	Y/N	Liver Disease	Y/N	Epilepsy/Seizures	Y/N
Heart Pacemaker/ Stent	Y/N	Diabetes Type 1 or 2	Y/N	Hepatitis A, B, C	Y/N	Psychiatric Care	Y/N
Heart Murmur/ Mitral Valve Prolapse	Y/N	Yellow Jaundice	Y/N	Nervousness	Y/N	Drug/Alcohol Addiction	Y/N
Rheumatic Fever	Y/N	Hypoglycemia	Y/N	Alzheimer's Disease	Y/N	Blood Transfusion	Y/N
High Blood Pressure	Y/N	Excessive Thirst	Y/N	AIDS/HIV	Y/N	Hemophilia (bleeder)	Y/N
Low Blood Pressure	Y/N	Artificial Joints/Hips	Y/N	Recent Weight Loss	Y/N	Bleed Easily	Y/N
Blood Disease	Y/N	Kidney Trouble	Y/N	Cancer	Y/N	Herpes	Y/N
Anemia	Y/N	Ulcers	Y/N	Chemotherapy/ Radiation	Y/N	Venereal Disease	Y/N
Sickle Cell Anemia	Y/N	Asthma	Y/N	Thyroid Disorder	Y/N	Canker/Cold Sores	Y/N
Chest Pain	Y/N	Hay Fever	Y/N	Arthritis/Gout	Y/N	Sleep Apnea	Y/N
Shortness of Breath	Y/N	Lung Disease	Y/N	Rheumatism	Y/N	Frequent Headaches	Y/N
Blood Thinners	Y/N	Emphysema	Y/N	Cortisone Medication	Y/N	Dry Mouth/Eyes	Y/N
						Shingles	Y/N

Please complete other side

Are you allergic to any of the following?

Local Anesthetics ("Novocain")	Y/N	Penicillin or other Antibiotics	Y/N	Sulfa Drugs	Y/N
Barbiturates, sedative or sleeping pills	Y/N	Aspirin, Acetaminophen or Ibuprofen	Y/N	Codeine or narcotics	Y/N
Reactions to metals	Y/N	Latex or Rubber Dams	Y/N	Iodine	Y/N

Any other allergies not listed: _____

_____

Do you use tobacco Products?	Y/N	Type/Frequency_____
Have you ever taken Fosamax or other bisphosphonate?	Y/N	_____
Have you had any past or recent surgical procedures?	Y/N	_____
Have you had any negative past dental experiences?	Y/N	_____
Is there anything you would like to change with your smile?	Y/N	_____
What can we do to make your appointment more pleasant?		_____

WOMEN:

Are you taking contraceptives or other hormones?	Y/N	_____
Are you Pregnant ?	Y/N	Expected Due Date_____
Are you nursing?	Y/N	
Have you reached menopause?	Y/N	If so, any symptoms? _____

MEN:

Are you/have you taken medication for erectile dysfunction?	Y/N	_____

Please list any medications and/or supplements you are currently taking. Please include dose and reason.

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Patient/Parent Signature ***Date***

_____ _____

Dentist Signature ***Date***

DENTAL HEALTH HISTORY

Name_____

Are you apprehensive about dental treatment? ..... Y/N
Have you had bad problems with previous dental treatment?..... Y/N
Do you gag easily? ..... Y/N
Do you wear dentures? ..... Y/N
Does food catch between your teeth?..... Y/N
Do you chew on only one side of your mouth?..... Y/N
Do you avoid brushing any part of your mouth due to pain?..... Y/N
Do your gums bleed easily?..... Y/N
Do your gums bleed when you floss?..... Y/N
Do your gums feel swollen or tender?..... Y/N
Have you ever noticed slow-healing sores in or about your mouth?..... Y/N
Are your teeth sensitive?..... Y/N
Do you feel twinges of pain when your teeth come in contact with:
Hot foods or liquids?..... Y/N
Cold foods or liquids? ..... Y/N
Sours? ..... Y/N
Sweets? ..... Y/N
Do you take fluoride supplements?..... Y/N
Are you dissatisfied with the appearance of your teeth?..... Y/N
Do you prefer to save your teeth?..... Y/N
Do you want complete dental care?..... Y/N
How often do you brush?_____
How often do you floss?_____
Does your jaw make noise so that it bothers you or others?..... Y/N
Do you clench or grind your jaws frequently?..... Y/N
Do your jaws ever feel tired?..... Y/N
Does your jaw get stuck so that you can't open freely?..... Y/N
Does it hurt when you chew or open wide to take a bite?..... Y/N
Do you have earaches or pain in front of you ears?..... Y/N
Do you have any jaw symptoms or headaches upon awaking in the morning?..... Y/N
Does jaw pain or discomfort affect your appetite,
sleep, daily routine, or other activities?..... Y/N
Do you find jaw pain or discomfort extremely frustration or depressing?..... Y/N
Do you take medications or pills for pain or discomfort?
(pain relievers, muscle relaxants, antidepressants)..... Y/N
Do you have a temporomandibular (jaw) disorder (TMD)?..... Y/N
Do you have pain in the face, cheeks, jaws, joints, throat or temples?..... Y/N
Are you unable to open your mouth as far as you want?..... Y/N
Are you aware of an uncomfortable bite?..... Y/N
Have you had a blow to the jaw (trauma)?..... Y/N
Are you a habitual gum chewer or pipe smoker?..... Y/N
Other concerns_____

Signature of Patient_____ Date: _____

Signature of Dentist:_____ Date: _____

Financial Policy

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding about our office financial policy.

Payment is due at time of appointment. If you have dental benefits, we appreciate your estimated portion be paid on the day of service.

Please select the desired payment method *(select all that apply)*

- ❑ **Cash or Check**
- ❑ **Debit or Credit:** (Visa, MasterCard or Discover Card)
- ❑ **Dental Benefits:**
  If you have a dental plan, we are happy to bill them after your portion is paid on day of service and to help maximize your benefits. However, please keep in mind that dental plans do not determine treatment; they establish only what the employer is willing to offer as part of their employee benefit package. Plans vary, so please refer to your handbook or check with your company's HR department for details. Any balances owed after benefits are paid are solely the patient's responsibility. Dr. Tinkle currently participates as an in-network provider under Delta Dental which includes WDS (DD of WA) and ODS (MODA), on the premier level.
- ❑ **Care Credit:**
  Apply online at www.carecredit.com. Plans offered by Care Credit will be at the discretion of the dental practice. Inquire as to which plans are currently being offered at this office.

Child or dependents:
If treatment is rendered for your child or minor dependent and any persons other than legal guardian brings the child to the appointment, payment must be sent with child or accompanying adult on behalf of child.

Missed appointments:
We reserve the right to charge **$70.00** for appointments canceled or broken without ***48-hour advance notice***. Please help us serve you better by keeping scheduled appointments.

Pre-determination of dental treatment:
A pre-determination of dental benefits is done only by request and is at no charge for the first submission per procedure. In the event you choose to not proceed with the treatment after the pre-determination has been processed, and it expires, there will be a $25.00 administrative fee to re-submit a new pre-determination. This amount will credited back to your dental ledger once you do proceed with treatment. **Please keep in mind a pre-determination is not a guarantee of payment by your dental insurance company.**

I have read and fully understand the Financial Policy and agree to abide by the guidelines that are set forth on such policy. I am agreeing to pay any and all legal fees of charges incurred if collection becomes necessary. I further understand if there is an infraction of the Financial Policy, I will not be provided any future treatment by Dr. Amanda Tinkle and the designated staff.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1.5% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

_____ _____ _____

Patient's Signature | Date | Witness

_____ _____

Parent/Responsible Party's Signature | Relationship to Patient

Kristine Aadland 2 DMD PLLC
117 E. 39th Street
Vancouver WA 98663

Acknowledgement 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 Kristine Aadland 2 DMD PLLC. 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 offices 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.

Kristine Aadland 2 DMD PLLC 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 revision become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed or otherwise transmitted 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 person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)	
SPOUSE ONLY	❑ YES ❑ NO
ANY MEMBER OF MY IMMEDIATE FAMILY: (SPOUSE, CHILDREN, CHILDREN'S SPOUSES)	❑ YES ❑ NO
ANY MEMBER OF MY EXTENDED FAMILY: (PARENTS, GRANDCHILDREN)	❑ YES ❑ NO
OTHER *(PLEASE SPECIFY)*	❑ YES ❑ NO

_____ _____
Name of Patient (print) Patient Signature

_____ _____
Patient's personal representative (print) Personal Representative's Signature

_____ _____
Representative's telephone number Date

OFFICE USE ONLY BELOW THIS LINE

Acknowledgment 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):_____
  _____

Kristine Aadland 2 DMD, PLLC
117 E. 39th Street
Vancouver WA 98663

STATEMENT OF PRIVACY PRACTICES

We at Kristine Aadland's office are dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. The commitment of each employee to ensure that your health information is never compromised is a principle concept of our practice. We may, from time to time amend our privacy policies and practices but will always inform you of any changes that might affect your rights.

Protecting Your Personal Healthcare Information

We use and disclose the information we collect from you only as allowed by the Heath Insurance Portability and Accountability Act. This includes issues relating to your treatment, payment, and our dental care operations. However, your personal protected health information will never be otherwise given to anyone–even family member–without your written consent. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

Collecting Protected Heath Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, contact normal dental practice operations and comply with the law. This may include your name, address, telephone number(s), social security number, employment data, medical history, health records etc. While most of the information will be collected from you, we may obtain information from third parties if it is deemed necessary. Regardless of the source, the information will always be protected to the full extent of the law.

Disclosure of your Protected Health Information

As stated above, we may disclose information as required by law. This includes issues in which we are also obligated to provide information to law enforcement officials under certain circumstances. We will not use your information for marketing purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines and postcards unless you direct otherwise. We will never disclose, sell or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use or disclose will be fully investigated, addressed and mitigated as established by the HIPAA privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI.

Patient Rights

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an amount allowed by law. If you believe your right have been violated we urge you to notify us immediately. You can, also, notify the U.S. Department of Human Services. We thank you for being a patient at Amanda M. Tinkle, DMD, PS. Please let us know if you have any questions concerning your privacy rights and the protection of your personal health information.