Pacific Northwest Oral & Maxillofacial Surgeons

D. Rick Edwards, DDS | Carl K. Johnson, DDS | Ben R. Johnson, DMD

www.PNWOMS.com

PATIENT REGISTRATION

Mr. Mrs. Ms. Miss Dr. _____
FIRST NAME M.I. LAST NAME NICKNAME

Date of Birth:_____ Gender: ❑M ❑F SSN # _____-_____-_____

Patient home address_____City_____State_____Zip_____

Home phone #_____Work/Cell phone #_____ Email_____
How do you prefer to be contacted? □Home phone □Work phone □Cell phone □Email □ mail
If you prefer to be contacted by Cell phone- may we leave automated messages on your voicemail? □Yes □No

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ACKNOWLEDGEMENT OF PRIVACY RIGHTS

My signature confirms that I have been informed that I have rights to privacy regarding my protected health information, and I have been given the opportunity to review this office's *Notice of Privacy Practices* as required by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

- Provide and coordinate treatment among health care providers who may be involved in my care
- Obtain payment from third-party payers for my health care services
- Conduct normal health care operations

Patient Name: _____ ☐ Self ☐ Parent ☐ Other & Relation _____

Emergency Contact: _____ Home: _____ Work/Cell: _____

Relationship to Patient: ☐ Spouse ☐ Parent ☐ Other & Relation _____

May we discuss your personal information with your Emergency Contact? □***Yes*** □***No***
If YES, you must list this person below:

I give permission for you to discuss my Medical and/or Financial information with:

Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____
Name: _____ Relationship to Patient: _____

□ *Please do not disclose my information with anyone except my doctor and insurance (if applicable)*
Dependent family members also covered by this acknowledgement

I grant my permission for PNWOMS to use photographs or digital images taken during my visit(s)for promotional and/or educational purposes. **[ ]YES [ ]NO**

Who may we thank for referring you?_____ Phone # _____

Who is your Dentist _____Phone # _____

Who is your Physician _____Phone # _____

PATIENT/GUARDIAN SIGNATURE: _____**DATE: _____**

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FINANCIAL POLICY

Please fill out this section even if you are the person financially responsible!

Are you 18 years or older? ☐**Yes** ☐**No** If yes, please note that you are financially responsible for yourself. If your parent or guardian is financially responsible for you—they will need to be present at your Examination/Consultation appointment, and will need to sign all necessary paperwork.

Person financially responsible for account: ☐Self ☐Parent ☐Other & Relation:_____

Name_____ Date of Birth _____ SSN# _____-_____-_____

Billing address (if different than patient) _____ City _____ State _____ Zip _____

Home # _____Work phone # _____ Employer _____

When you are in the midst of being treated for a medical or dental problem, it's easy to forget that a doctor's office is also a business. We understand that. Yet we also want our patients to understand that an important part of any business is also collecting payments for the services it provides. In the interest of both good medicine and good business, we believe it's best to establish a policy to avoid any misunderstandings later. As a result we have developed this billing policy.

1. You are responsible for paying your bill.
   Your insurance coverage is a contract between you and your company. Our office is not involved in setting your coverage limits, exclusions to your contract, or waiting periods. That means it's primarily your responsibility to see that your insurance company covers your bill.

2. We ask that you pay by cash, check or credit card on the day that services are rendered.
   While your insurance company may reimburse a portion of the cost of the medical or dental care, we ask that you pay the deductible and/or your estimated portion on the date that treatment is rendered. In individual instances payment plans may be extended for a short period of time or 3rd party financing may be available. Please talk with our business administrator prior to your appointment if you need to make financial arrangements.

3. How we handle insurance claims.
   We will make every attempt to verify eligibility and co-payment amounts prior to your surgery. Please keep in mind that if you have recently undergone treatment at another office whose claims have not been processed by your insurance company when we call, those benefits may not have been factored into your estimate and your ending balance may differ. After surgery or treatment we will bill your insurance carrier for their portion of the bill. We will be prompt in handling any requests for information to facilitate the claim.

4. We invite you to discuss our fees or financial policies with us.
   We are always happy to answer any questions about costs, insurance claims, billing questions, or financial plans.

AGREEMENT TO PAY:

I request and authorize Pacific Northwest Oral & Maxillofacial Surgeons to provide me with medical or dental services. I understand that I am personally responsible for the charges incurred for the services I receive. I agree to make full payment for services I receive unless prior arrangements have been made in writing.

I agree to pay all reasonable attorney fees and costs of collection incurred by PNWOMS if my account is not paid as agreed. I also agree to pay interest on my unpaid balance at the rate of 12% per annum commencing 90 days after the date of service.

As a patient (or guardian of a patient) I understand that this office does not acknowledge agreements between parents accepting or denying financial responsibility for services provided. We consider the guardian (custodial) parent to be responsible for payment of services received.

I hereby authorize PNWOMS at its discretion, to bill my insurance carrier and any other persons or parties who may be liable for payment of these services. I also authorize my insurance carrier to make payment directly to PNWOMS.

PATIENT/GUARDIAN SIGNATURE: _____**DATE:** _____

☐ **INSURANCE COVERAGE** (please fill in each field) ☐ **PRIVATE PAY** (you may skip this page)

PRIMARY DENTAL **INSURANCE NAME** _____

Insurance Billing address_____ Phone #_____

Name of subscriber _____ D.O.B. _____Relation to patient_____

Address of subscriber (if different than responsible party) _____

City _____ State _____ Zip _____ Home # _____

ID# (usually SSN#) _____Group#_____

Subscriber's employer _____Work # _____

SECONDARY DENTAL **INSURANCE NAME** _____

Insurance Billing address_____ Phone # _____

Name of subscriber _____ D.O.B. _____Relation to patient_____

Address of subscriber (if different than responsible party) _____

City _____ State _____ Zip _____ Home # _____

ID# (usually SSN#) _____Group#_____

Subscriber's employer _____Work # _____

PRIMARY MEDICAL **INSURANCE NAME** _____

Insurance Billing address_____ Phone # _____

Name of subscriber _____ D.O.B. _____Relation to patient_____

Address of subscriber (if different than responsible party) _____

City _____ State _____ Zip _____ Home # _____

ID# (usually SSN#) _____Group#_____

Subscriber's employer _____Work # _____

SECONDARY MEDICAL **INSURANCE NAME** _____

Insurance Billing address_____ Phone # _____

Name of subscriber _____ D.O.B. _____Relation to patient_____

Address of subscriber (if different than responsible party) _____

City _____ State _____ Zip _____ Home # _____

ID# (usually SSN#) _____Group#_____

Subscriber's employer _____Work # _____

INFORMATION RELEASE: I authorize the release of any information requested by my insurance company regarding my treatment.
NOTE: This office will not release information regarding your care, or furnish copies of your record to anyone without your signed permission.

PATIENT/GUARDIAN SIGNATURE: _____**DATE:** _____

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Patient Name _____

We appreciate your confidence in allowing us to provide care. Correct answers to the following questions will allow us to provide care appropriate to your needs. This information is confidential. Any omissions or incorrect information could compromise care and lead to serious complications. If you have questions, please ask for clarification.

Why are you seeking treatment? _____

PLEASE ANSWER EACH **BOLD** SUBTITLED SECTION WITH **YES** OR **NO**.
FOR EACH **YES** SECTION, YOU MUST ANSWER ENTIRE SECTION.

1. **Do you have, or have you had, any of the following?**

HEART PROBLEMS [ ]YES [ ]NO
[ ] Heart implants? Valves, Graft?
[ ] Rheumatic Fever/Rheumatic Heart Disease
[ ] Congenital Heart Disease
[ ] Heart Attack – If so, what year? _____
[ ] Fainting or dizziness
[ ] Heart Murmur/Irregular Heartbeat/Palpitations
[ ] Coronary Heart Disease/Artery Disease
[ ] Angina/Chest Pain
[ ] High Blood Pressure
[ ] Low Blood Pressure
[ ] Pacemaker
[ ] Heart Surgery
What type of heart surgery, and when? _____
_____

RESPIRATORY PROBLEMS [ ]YES [ ]NO
[ ] Asthma
[ ] Seasonal Allergies
[ ] Emphysema
[ ] Tuberculosis
[ ] Shortness of breath/Difficulty breathing
[ ] Snoring/Sleep Apnea
[ ] Pneumonia/Bronchitis/Chronic cough
[ ] Sinus or Recurring Nasal problems

NEUROLOGICAL PROBLEMS [ ]YES [ ]NO
[ ] Seizures or Convulsions
[ ] Epilepsy
[ ] Psychiatric treatment
[ ] Nervous Disorder/Breakdown
[ ] Mental Health Problem
[ ] Autism
[ ] Developmentally Delayed
[ ] Stroke - If so, what year? _____

ENDOCRINE/BLOOD PROBLEMS [ ]YES [ ]NO
[ ] Anemia
[ ] Liver Disease/Jaundice
[ ] Kidney Disease
[ ] Are you on Dialysis? What Days? _____
[ ] Bleeding Disorder
[ ] Bleeding tendency/Bruise Easily
[ ] Hepatitis A, B or C
[ ] Diabetes
How often do you check your blood sugar? _____
What is your average value? _____
[ ] Thyroid Disease (High or Low)
[ ] Blood Transfusion
[ ] Sexually Transmitted Disease
If yes, which one? _____

GASTROINTESTINAL PROBLEMS [ ]YES [ ]NO
[ ] Eating disorder
[ ] Stomach Ulcers or Colitis
[ ] Frequent or recurring Mouth Sores
[ ] Irritable Bowel Syndrome

MUSCULOSKELETAL PROBLEMS [ ]YES [ ]NO
[ ] Limited range of motion (Head/Back/Knee/Hip/Etc.)
[ ] Joint replacements (Hip/Knee/Shoulder/Etc.)
[ ] Osteoporosis/Osteopenia
[ ] Arthritis

OTHER PROBLEMS [ ]YES [ ]NO
[ ] Glaucoma
[ ] Cancer of any kind
If so, what type? _____
[ ] Chemotherapy/Radiation
[ ] Recurring infections of any kind
[ ] Any disease, drugs, or transplant operation that may suppress your immune system

MEDICATIONS [ ]YES [ ]NO

Please list any medications you are now taking. Please include prescription and non-prescription (over the counter) drugs. Please list any blood thinners. Please include any herbal medications or health medications or medications used for weight gain or loss, or drugs used to enhance athletic performance. Please include any history of street drugs. If needed we can make a copy of your drug list.

_____

_____

_____

_____

HAVE YOU EVER TAKEN A BISPHOSPHONATE DRUG (drug used to strengthen bones) **[ ]YES [ ]NO**

Examples include: Fosamax, Boniva, Actonel, Aredia, Skelid, Bonefos, and Zometa.

If so, please list _____

SOCIAL HISTORY [ ]YES [ ]NO

[ ] Do you smoke cigarettes

If so, how many daily? _____

[ ] Do you smoke cigars or use chewing tobacco

[ ] Do you drink alcohol?

If yes, how much? _____

[ ] Have you ever sought professional care for drug Abuse or alcoholism

[ ] Do you have a history of drug abuse

[ ] Do you have a pain management contract with your physician?

MEDICATION ALLERGIES [ ]YES [ ]NO

If so, please list _____

_____

_____

GENERAL ANESTHESIA [ ]YES [ ]NO

[ ] Do you wear contact lenses

[ ] Have you ever been given General Anesthesia

[ ] If so, did you experience any side effects

DO YOU OR A FAMILY MEMBER HAVE A HISTORY OF OR BEEN DIAGNOSED WITH MALIGNANT HYPERTHERMIA? [ ]YES [ ]NO

DO YOU HAVE any other medical disease, condition or problem not listed above that you think the doctor should know about **[ ]YES [ ]NO**

If yes, please elaborate _____

_____

_____

PLEASE INDICATE

Your current height _____ feet _____inches

Your current weight _____lbs

FEMALES [ ]YES [ ]NO

[ ] Are you pregnant

If so, current trimester _____

[ ] Are you using birth control medication

I understand the importance of providing a truthful health history to assist my doctor in providing the best care possible. The information I have provided here is complete and accurate.

PATIENT/GUARDIAN SIGNATURE: _____**DATE: _____**

The PNWOMS team believes that health care is a cooperative effort between you as the patient, your surgeon and our team. Recognizing that the patients have rights, we have listed below the things you may expect and in turn your responsibilities while a patient at our office.

PATIENT RIGHTS AND RESPONSIBILITES

YOUR RIGHTS:

- *You have the right to considerate and respectful care.*
- *You have the right to obtain from your surgeon complete current information concerning your diagnosis, treatment, and prognosis in terms you can be reasonably expected to understand. When it is not advisable to give such information to you, the information should be made available to an appropriate person on your behalf. You have the right to know, by name, the surgeon responsible for coordinating your care.*
- *Prior to the start of procedures and/or treatments that involve substantial risks, you have the right to receive, from your surgeon, the information necessary to give informed consent. You have the right to request and receive information concerning medical alternatives. You have the right to know the name of the person responsible for the procedures and/or treatment.*
- *You have the right to refuse treatment and to be informed of the medical consequences of your action.*
- *You have the right to pain assessment and appropriate management.*
- *You have the right to every consideration of your privacy concerning your care program.*
- *You have the right to expect that all communications and records pertaining to your care will be treated as confidential except as otherwise provided by law or contractual agreements.*
- *You have the right to expect that the PNWOMS team, within its capacity, will make a reasonable response to your request for services.*
- *You have the right to change your care to another qualified provider. We request that you notify our office if you choose to change providers.*
- *You have the right to obtain information as to any relationship between PNWOMS and other health care and educational institutions in so far as your care is concerned. You have the right to obtain information as to the existence of any professional relationships among individuals, by name, which are treating you.*
- *You have the right to expect reasonable continuity of care. You have the right to expect your surgeon inform you of your continuing health care requirements following discharge.*
- *You have the right to examine and receive and explanation of your bill regardless of source of payment.*
- *You have the rights to know what PNWOMS rules and regulations apply to your conduct as a patient.*
- *It is the PNWOMS teams' goal and commitment to provide a safe and secure environment for all our patients, visitors and employees.*
- *You have the right to receive credentialing information for the healthcare professionals at the PNWOMS Office. This information is available on our website, www.PNWOMS.com, or can be provided in hard copy, upon request.*

YOUR RESPONSIBILITES:

- *Your surgeon expects that you or your family will provide information about past illnesses, hospitalization, medications and other matters relating to your health history in order to effectively treat your illness.*
- *PNWOMS expects that you will cooperate with all personnel and ask questions if directions and/or procedures are not clearly understood.*
- *You are expected to be considerate of other patients and personnel and to assist in the control of noise, smoking, and the number of your visitors. You are also expected to be respectful of the property of other persons and the property of the PNWOMS Office.*
- *In order to facilitate your care and the efforts of your surgeon and the PNWOMS team in their efforts to provide care, you are expected to follow their instructions and medical orders.*
- *Duly authorized members of your family are expected to be available to PNWOMS personnel for review of your treatment in the event you are unable to properly communicate with the surgeon or nurse.*
- *It is understood that you assume the financial responsibility of paying for all services rendered whether through third party payers (your insurance company) or being personally responsible for payment for any services which are not covered by your insurance company.*
- *It is expected that you will not take drugs which have not been administered by the PNWOMS team and that you will not consume alcoholic beverages or toxic substances not allowed by your surgeon.*
- *You are expected to observe all safety regulations that you have been made aware of by both verbal and other means.*
- *You are fully responsible for reading, understanding and signing all the PNWOMS forms associated with your care, or for bringing with you a designated person who can assist you with reading and understanding these forms. You should ask questions about anything in the forms that you do not understand prior to signing them.*

The PNWOMS team wants to listen to patient suggestions, concerns and the concerns voiced by family members or visitors. It is our goal to review all suggestions and concerns and to provide a response that describes how the issue(s) were reviewed and actions that were taken to resolve. Patients who express a suggestion, concern or grievance, will not have their future access to care compromised in any way. Grievances may be submitted verbally or in writing. To share a suggestions, concern or grievance, please contact any staff member or contact our business office at 253-242-7237, fill out a suggestion card or email us at office@pnwoms.com

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY 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 health information used or disclosed to us in any form, whether electronically, on paper, or orally, 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 HIPAA, 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 records 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 providers or specialists involved in the continuation of your care.

- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. For example, treatment information is disclosed 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 reviewed periodically for training purposes, or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, or other personal representative to the extent necessary to help with your healthcare or with payment for your healthcare. In addition, we may use your confidential information to remind you of appointments or to pre-medicate by sending reminder postcards and/or leaving recorded messages at home and/or work. We may also disclose protected health information for any lawful purpose as required in the HIPAA regulations. 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 can 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.

- The right to request an amendment to your protected health information.

- The right to receive an accounting of disclosures of protected health information outside of treatment, payment and health care operations.

- The right to obtain a paper copy of this notice from us upon request.

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 April 14, 2003 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:

Sara Peterson, Privacy Officer
Pacific Northwest Oral & Maxillofacial Surgeons
601 South Carr Road, Suite #300
Renton, WA 98055
(253) 242-7237 or (800) 618-1875

For more information about HIPAA or to file a complaint:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C. 20201
(877) 696-6775 (toll free)