ACQUAINTANCE FORM

Kathryn DeWood DMD

Date: _____

Patient Name: _____Single____Married____Widowed____Divorced____

Address: _____ City: _____

State: _____ Zip: _____ Social Security Number: _____

Home Phone: _____ (Other) Phone: _____

Cell Phone: _____ Birth date: _____

Employer: _____ Occupation: _____

Person Responsible for Account: _____

Do you have a dental benefits plan through your insurance provider? _____

How did you hear about Dr. DeWood? _____

Whom may we thank for this referral? _____

These are things important to me about my dental health:

(Please Circle One)

1. **My mouth is**
   A.) very comfortable
   B.) moderately comfortable
   C.) uncomfortable

2. **I (I am)**
   A.) think the appearance of my mouth is excellent
   B.) satisfied with the appearance of my mouth
   C.) dissatisfied with the appearance of my mouth

3. **I**
   A.) will do anything to keep my natural teeth
   B.) want to keep my teeth, but have a certain budget of time and money I am willing to spend on them
   C.) don't care whether I keep my teeth or not

4. **I**
   A.) have set goals for my oral health with a previous dentist
   B.) want to set goals concerning my dental health
   C.) never set goals concerning my dental health

5. **I**
   A.) have always done the best that was recommended for my dental health
   B.) have not done what dentists have recommended for my mouth
   C.) rarely go, and don't care much about having my dental work completed.

6. **I have**
   A.) put dentistry for myself and my family high on my priority list
   B.) put dentistry for myself and my family low on my priority list

7. **I think my present state of dental health is:**
   A.) excellent
   B.) good
   C.) poor

8. **I aspire for my oral health to be:**
   A.) excellent
   B.) good
   C.) poor

9. **What is/are your primary concerns?**

_____

_____

_____

_____

_____

_____

_____

MEDICAL HISTORY

Patient Name _____ Nickname _____ Age _____

Name of Physician/and their specialty _____

Most recent physical examination _____ Purpose _____

What is your estimate of your general health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

DO YOU HAVE or HAVE YOU EVER HAD:	YES	NO
1. hospitalization for illness or injury _____	☐	☐
2. an allergic reaction to		
☐ aspirin, ibuprofen, acetaminophen, codeine		
☐ penicillin		
☐ erythromycin		
☐ tetracycline		
☐ sulfa		
☐ local anesthetic		
☐ fluoride		
☐ metals (nickel, gold, silver, _____)		
☐ latex		
☐ other _____		
3. heart problems, or cardiac stent within the last six months __	☐	☐
4. history of infective endocarditis _____	☐	☐
5. artificial heart valve, repaired heart defect (PFO) _____	☐	☐
6. pacemaker or implantable defibrillator _____	☐	☐
7. artificial prosthesis (heart valve or joints) _____	☐	☐
8. rheumatic or scarlet fever _____	☐	☐
9. high or low blood pressure _____	☐	☐
10. a stroke (taking blood thinners) _____	☐	☐
11. anemia or other blood disorder _____	☐	☐
12. prolonged bleeding due to a slight cut (INR > 3.5) _____	☐	☐
13. emphysema, shortness of breath, sarcoidosis _____	☐	☐
14. tuberculosis, measles, chicken pox _____	☐	☐
15. asthma _____	☐	☐
16. breathing or sleep problems (i.e. sleep apnea, snoring, sinus)	☐	☐
17. kidney disease _____	☐	☐
18. liver disease _____	☐	☐
19. jaundice _____	☐	☐
20. thyroid, parathyroid disease, or calcium deficiency _____	☐	☐
21. hormone deficiency _____	☐	☐
22. high cholesterol or taking statin drugs _____	☐	☐
23. diabetes (HbA1c = _____) _____	☐	☐
24. stomach or duodenal ulcer _____	☐	☐
25. digestive disorders (i.e. celiac disease, gastric reflux) _____	☐	☐

	YES	NO
26. osteoporosis/osteopenia (i.e. taking bisphosphonates) __	☐	☐
27. arthritis, rheumatoid arthritis, lupus _____	☐	☐
28. glaucoma _____	☐	☐
29. contact lenses _____	☐	☐
30. head or neck injuries _____	☐	☐
31. epilepsy, convulsions (seizures) _____	☐	☐
32. neurologic disorders (ADD/ADHD, prion disease) _____	☐	☐
33. viral infections and cold sores _____	☐	☐
34. any lumps or swelling in the mouth _____	☐	☐
35. hives, skin rash, hay fever _____	☐	☐
36. STI / STD _____	☐	☐
37. hepatitis (type ___) _____	☐	☐
38. HIV / AIDS _____	☐	☐
39. tumor, abnormal growth _____	☐	☐
40. radiation therapy _____	☐	☐
41. chemotherapy, immunosuppressive _____	☐	☐
42. emotional problems _____	☐	☐
43. psychiatric treatment _____	☐	☐
44. antidepressant medication _____	☐	☐
45. alcohol / street drug use _____	☐	☐
ARE YOU:		
46. presently being treated for any other illness _____	☐	☐
47. aware of a change in your health in the last 24 hours (i.e. fever, chills, new cough, or diarrhea) _____	☐	☐
48. taking medication for weight management (i.e. fen-phen)	☐	☐
49. taking dietary supplements _____	☐	☐
50. often exhausted or fatigued _____	☐	☐
51. experiencing frequent headaches _____	☐	☐
52. a smoker, smoked previously or use smokeless tobacco _	☐	☐
53. considered a touchy person _____	☐	☐
54. often unhappy or depressed _____	☐	☐
55. FEMALE - taking birth control pills _____	☐	☐
56. FEMALE - pregnant _____	☐	☐
57. MALE - prostate disorders _____	☐	☐

Describe any current medical treatment, impending surgery, genetic/development delay, or other treatment that may possibly affect your dental treatment. (i.e. Botox, Collagen Injections)

_____

List all medications, supplements, and or vitamins taken within the last two years

Drug	Purpose	Drug	Purpose

Ask for an additional sheet if you are taking more than 6 medications

PLEASE ADVISE US IN THE FUTURE OF ANY CHANGE IN YOUR MEDICAL HISTORY OR ANY MEDICATIONS YOU MAY BE TAKING.

Patient's Signature _____ Date _____

Doctor's Signature _____ Date _____

DENTAL HISTORY

Name_____ Nickname_____ Age_____
Referred by_____How would you rate the condition of your mouth? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Previous Dentist _____How long have you been a patient?_____Months/Years
Date of most recent dental exam _____/_____/_____ Date of most recent x-rays _____/_____/_____
Date of most recent treatment (other than a cleaning) _____/_____/_____
I routinely see my dentist every: ☐ 3 mo. ☐ 4 mo. ☐ 6 mo. ☐ 12 mo. ☐ Not routinely

WHAT IS YOUR IMMEDIATE CONCERN? _____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:	**YES**	**NO**
PERSONAL HISTORY		
1. Are you fearful of dental treatment? How fearful, on a scale of 1 (least) to 10 (most) [___] _____	☐	☐
2. Have you had an unfavorable dental experience? _____	☐	☐
3. Have you ever had complications from past dental treatment? _____	☐	☐
4. Have you ever had trouble getting numb or had any reactions to local anesthetic? _____	☐	☐
5. Did you ever have braces, orthodontic treatment or had your bite adjusted? _____	☐	☐
6. Have you had any teeth removed? _____	☐	☐
GUM AND BONE		
7. Do your gums bleed or are they painful when brushing or flossing? _____	☐	☐
8. Have you ever been treated for gum disease or been told you have lost bone around your teeth? _____	☐	☐
9. Have you ever noticed an unpleasant taste or odor in your mouth? _____	☐	☐
10. Is there anyone with a history of periodontal disease in your family? _____	☐	☐
11. Have you ever experienced gum recession? _____	☐	☐
12. Have you ever had any teeth become loose on their own (without an injury), or do you have difficulty eating an apple? _____	☐	☐
13. Have you experienced a burning sensation in your mouth? _____	☐	☐
TOOTH STRUCTURE		
14. Have you had any cavities within the past 3 years? _____	☐	☐
15. Does the amount of saliva in your mouth seem too little or do you have difficulty swallowing any food? _____	☐	☐
16. Do you feel or notice any holes (i.e. pitting, craters) on the biting surface of your teeth? _____	☐	☐
17. Are any teeth sensitive to hot, cold, biting, sweets, or avoid brushing any part of your mouth? _____	☐	☐
18. Do you have grooves or notches on your teeth near the gum line? _____	☐	☐
19. Have you ever broken teeth, chipped teeth, or had a toothache or cracked filling? _____	☐	☐
20. Do you frequently get food caught between any teeth? _____	☐	☐
BITE AND JAW JOINT		
21. Do you have problems with your jaw joint? (pain, sounds, limited opening, locking, popping) _____	☐	☐
22. Do you feel like your lower jaw is being pushed back when you bite your teeth together? _____	☐	☐
23. Do you avoid or have difficulty chewing gum, carrots, nuts, bagels, baguettes, protein bars, or other hard, dry foods? _____	☐	☐
24. Have your teeth changed in the last 5 years, become shorter, thinner or worn? _____	☐	☐
25. Are your teeth crowding or developing spaces? _____	☐	☐
26. Do you have more than one bite and squeeze to make your teeth fit together? _____	☐	☐
27. Do you chew ice, bite your nails, use your teeth to hold objects, or have any other oral habits? _____	☐	☐
28. Do you clench your teeth in the daytime or make them sore? _____	☐	☐
29. Do you have any problems with sleep or wake up with an awareness of your teeth? _____	☐	☐
30. Do you wear or have you ever worn a bite appliance? _____	☐	☐
SMILE CHARACTERISTICS		
31. Is there anything about the appearance of your teeth that you would like to change? _____	☐	☐
32. Have you ever whitened (bleached) your teeth? _____	☐	☐
33. Have you felt uncomfortable or self conscious about the appearance of your teeth? _____	☐	☐
34 Have you been disappointed with the appearance of previous dental work? _____	☐	☐

Patient's Signature _____ Date_____

Doctor's Signature _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of DeWood Dental Arts. 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 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.

DeWood Dental Arts reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)

Spouse only	☐ **YES**	☐ **NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Children's Spouses)	☐ **YES**	☐ **NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	☐ **YES**	☐ **NO**
OTHER:	☐ **YES**	☐ **NO**

Name of patient (please print):

Patient signature (if 18+ years of age):

Patient's personal representative: (Please Print):

Personal Representative's signature:

Representative's Telephone Number: **Date:**

I GIVE PERMISSION ALLOWING DR DEWOOD AND STAFF TO LEAVE MESSAGES ON MY PHONE VOICEMAIL THAT MAY CONTAIN PROTECTED HEALTH INFORMATION. ☐ **YES** ☐ **NO**

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ **YES**	☐ **NO**	**Date Statement Provided: _____**
Reason for not obtaining patient signature:	☐	**Needed more time to review Statement**	
	☐	**Wanted to consult another person before signing**	
	☐	**Physically unable to sign**	

STATEMENT OF PRIVACY PRACTICES

DEWOOD DENTAL ARTS

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. 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 HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health 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, your personal information will always be protected to the full extent of the law.

DISCLOSURE OF YOUR PROTECTED HEALTHCARE INFORMATION

As stated above, we may disclose information as required by law. We are obligated to provide information to law enforcement and governmental officials under certain circumstances. We will not use your information for marketing or fund-raising 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 us otherwise. We will never use, 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 disclosure, 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

YOUR RIGHTS AS OUR PATIENT

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 rights have been violated, we urge you to notify us immediately. You can also notify the U.S. Department of Health and Human Services.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

DeWood Dental Arts

Kathryn L. DeWood, DMD

Dental Benefits Agreement

- The *estimated* amount not covered by your dental benefits plan is due prior to or at the time of treatment unless personalized financial arrangements have been completed previously.
- *With Assignment of Dental Benefits* to our office we are able to extend the courtesy of a *grace period* pending receipt of the benefits due to you from your dental benefits carrier.
- We are able to file all claims with all dental benefits companies electronically. If the benefit company has not issued payment 30 days after submission we ask that you contact your dental benefits company or your human resources director to create an inquiry regarding the benefits that are owed to you.
- Unpaid balances remaining on any account more than 30 days are subject to service charges unless personalized financial arrangements have been completed in writing. If the unpaid amount represents an estimated dental benefit and you have contacted your dental benefit company for payment, the service charges may be forgiven pending resolution of the problem. All amounts 60 days past due are subject to service charges unless personalized financial arrangements are made for payment of the balance

NAME PRINTED _____

Assignment of Benefits

I request payment of any dental benefit due to me for services in Dr. DeWood's office be paid directly to her and sent to her office at the address on the submitted form

_____ DATE _____

Dental Benefit Agreement

I have read and agree to the arrangement above. I wish to cooperate and assist Dr. DeWood in helping me utilize my dental benefits and agree to the terms of the Dental benefit Agreement

_____ DATE _____

Dental Insurance or Dental **Assistance**?

Dental Insurance is **NOT** really *Insurance* in the classic sense.

If you have needs other than healthy cleanings, your care will require an investment beyond what your "insurance" will cover. What value is there in healthy chewing and a healthy smile for you? Are you worth the investment?

It's not news that employers have reacted to the rising costs of Medical Insurance and Dental Benefits by shopping carefully for the policies that they offer their employees. Benefits are down, restrictions and exclusions are up.

Patients share their resulting frustration with us every day.

Adding to the frustration is the fact that dental benefits are often represented inaccurately, as if they were comparable to insurance. "Insurance", by definition, is protection against unpredictable or catastrophic loss. Most dental benefit plans specifically *exclude* many of the services that are required to appropriately treat a complex problem, and virtually all dental benefit plans have low annual maximums. Services that are fully or almost fully provided for within the benefits are those that are not only predictable, but expected, such as routine exams, x-rays, healthy cleanings, etc. Further, policies that do provide benefits for less common dental services, such as crowns and treatment for gum disease, provide them at a much lower percentage than preventive care, and with a low dollar limit per year.

A common misconception is that dental benefits cover what you need. We believe that is a danger to your health, because it implies that *if it isn't covered, you don't need it.* Your dental benefit plan was never designed to **get** you healthy. It can be an excellent source of assistance in ***maintaining*** your health once you are healthy, and for that reason we're really pleased to help you utilize that assistance. The fact is, unless you have excellent dental health, your needs will require that you make an investment.

We invest in what we value. Home improvement, education, and vacations are all examples of things we pay for, by choice, because we value them. We don't presume to know where your dental health fits in your value system. That's for you to decide. Just know that we believe that you are worth the investment.

DeWood Dental Arts Kathryn L. DeWood, DMD 425.726.0021
14420 Bel-Red Road #107 Bellevue, Washington

PLEASE INITIAL:_____

DeWood Dental Arts

Kathryn L. DeWood, DMD

FINANCIAL INFORMATION

We are pleased to offer the following options:

- **CASH OR PERSONAL CHECK**
- **PERSONAL CREDIT AND DEBIT CARDS**
  We accept VISA, MasterCard, Discover, American Express
- **FINANCING OPTIONS**
  We can assist your application to Care Credit

Here are answers to some frequently asked questions

- Payment is due at the time of service unless personalized financial arrangements have been completed in writing.
- Any payments past due and any unpaid balances not part of a personalized financial arrangement are subject to a service charge.

IF you are covered under a dental benefits plan

- As a service to our patients, we file all claims with your dental benefits company. If balances are not received within 30 days of submission we ask that you contact your dental benefits company or your human resources director to create an inquiry regarding the benefits that are owed to you.
- Any co-payment established by your dental benefits company is due at the time of service unless financial arrangements have been discussed and completed in writing.
- Balances remaining on any account more than 30 days are subject to service charges unless personalized financial arrangements have been completed in writing.

Sign: _____ Date: _____
(Responsible Party)