PROGRESSIVE
DENTAL GROUP

Welcome to our office. We are committed to providing you with exceptional state of the art dentistry, based on your individual needs and always meeting the Progressive Dental Group standard of care which ensures excellence.

Patient name: _____ Date of Birth: _____ Sex: _____ Age: _____

Home & billing address: _____ City: _____ State: _____ Zip: _____

Home phone: _____ Cell: _____ Email: _____

Circle Your Preferred Method of Contact for Appointment Reminders: Home Phone Message Cell Phone Message Text Email

Your Occupation: _____ Who may we thank for referring you? _____

Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____

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

Primary Insurance – Required to Bill Insurance	**Secondary Insurance – Required to Bill Insurance**
Subscribers Name	Subscribers Name
____/____/____ Date of Birth _____ Social Security #	____/____/____ Date of Birth _____ Social Security #
Subscribers Relationship to Patient	Subscribers Relationship to Patient
Employer Work Phone #	Employer Work Phone #
Name of Insurance Company	Name of Insurance Company
Group # ID # -Required to bill insurance	Group # ID # -Required to bill insurance

We accept most insurance – We are preferred providers for Delta Dental, Aetna, Ameritas, Cigna, Guardian, Metlife, Premera, Principal, Regence, Standard and United Concordia. Payment of your co-insurance or co-pay is due at the time of service. Your out-of-pocket amount is an estimate only. Regardless of insurance coverage you are responsible for all fees. We are happy to file the forms necessary to see that your insurance pays their portion to our office, however, if the outstanding insurance amount due is not received within 30 days, you will be responsible for the balance due. If payment from your insurance results in a credit on your account your refund will be sent promptly.

Payment of Services – Payment is due at time of service. We accept Cash, Check, Visa, MasterCard, American Express, Discover and have Payment Plans available upon approved credit through CareCredit.

Patient Agreement – I acknowledge that the fee for my dental treatment is my responsibility, and will assist Progressive Dental Group in receiving payment from my insurance in a timely fashion. If my account should become delinquent, it may be subject to additional collection charges and fees.

Cancellations & Missed Appointments – We consider appointment times to be confirmed when reserved, and make every effort to provide a courtesy reminder of your preference, either by way of phone call, text message, or email. We kindly request that you provide 48 hours' notice for any appointment changes, and reserve the right to impose nominal fees for habitual last-minute appointment changes, dependent upon the length of the appointment missed, generally $50 per hour.

Signature: _____ Date: _____

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Patient Name: _____

Phone: _____

The information provided on this form is important to your dental health. If there have been any changes in your health, please tell us.

Are you under a physician's care now? Yes No If yes, please explain: _____
Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: _____
Have you ever had a serious head or neck injury? Yes No If yes, please explain: _____
Are you taking any medications, pills, or drugs? Yes No If yes, **please list in space provided at bottom of form**
Have you been diagnosed with sleep apnea? Yes No If yes, was it MILD, MOD or SEVERE? _____
Are you currently using or have been prescribed a CPAP or other sleep appliance? Yes No If yes, how often: _____
Have you been told you snore or stop breathing while you you sleep? Yes No If yes, please explain: _____
Do you use tobacco or cannabis? Yes No If yes, how often: _____
Do you use controlled substances? Yes No If yes, type and frequency: _____
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Nursing? Yes No Taking oral contraceptives? Yes No IUD? Yes No

Are you allergic to any of the following? □ Aspirin □ Penicillin □ Codeine □ Sulfa drugs □ Local Anesthetics □ Acrylic □ Metal □ Latex □ Other If yes please explain: _____

Do you have, or have you had, any of the following? *Please circle YES or NO to every question

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anaphylaxis	Yes	No	Type I Type II Drug Addiction	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Disease	Yes	No				Leukemia	Yes	No	Stomach/ Intestinal Disease	Yes	No
Blood Transfusion	Yes	No	Frequent Cough	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Breathing Problems	Yes	No	Frequent Headaches	Yes	No	Lung Disease	Yes	No	Swelling of Limbs	Yes	No
Bruise Easily	Yes	No	Glaucoma	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Cancer	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chemotherapy	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Chest Pains	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Congenital Heart Disorder	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Convulsions	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No

Please list ALL prescription medications you are taking: _____

_____

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

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patients) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian _____ Date: _____

Relationship to Patient: _____ Printed name: _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect May 2011, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations' include quality assessment and in improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

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Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security- We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement officials having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters)

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice If you request copies, we will charge you $0.10 for each page, $15 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed you health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years. If you request this accounting more than once in a 12- month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. WE are not requested to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency)

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Website or by electronic mail (email), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Service.

Contact Officers:	John Skibiel, DDS, Ranjiv Hayre, DDS, Adam Berry, DDS
Telephone:	425-368-0608
E-mail:	info@progressivedentalnw.com
Address:	1617 183rd Street S.E. Suite 2, Mill Creek WA 98012

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Telephone: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENT CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, healthcare operations among a number of health care providers who may be involved in that treatment directly or indirectly and obtain payment from third-party payers for my health care services. I understand that information at Progressive Dental Group is protected and I further understand that in order for Progressive Dental Group and their staff to leave detailed messages containing specific medical and dental information on my voicemail, answering machine or with the person answering the phone, I need to give permission to Progressive Dental Group and Staff to do so.

Consent to Leaving Message: I consent to information regarding my child/children's detailed appointment reminders, instructions or post-operative information/instructions be left on my voicemail, answering machine or with the person answering the telephone.
Please Circle One: **YES** **NO**

Consent for Shared Information with Family and Friends: The name(s) written in below are family members or friends to whom I grant permission for my health and dental care providers and their representatives at Progressive Dental Group to verbally discuss my care, insurance and financial information and grant them permission to disclose health and dental information that is relevant to my care or relevant to financial arrangements, insurance information or payment. Please Circle One: **YES** **NO**

Any Member of my immediate family (i.e. Spouse, Children, Siblings, etc.) covered by this acknowledgement: _____

Any Members of my extended family or friends (i.e. Parents, Grandchildren) covered by this acknowledgement: _____

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. Under the HIPPA Privacy Law we are permitted and we may take a professional judgement that certain disclosures are inyour best interest even without this signature.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting: John Skibiel, DDS, Ranjiv Hayre, DDS, Adam Berry, DDS. At 1617 183rd Street S.E. Suite 2, Mill Creek WA 98012. Telephone: 425-368-0608. Email: info@progressivedentalnw.com

Right to Revoke: You will have the right to revoke this Consent or any shared information persons listed above at any time by giving us written notice of your revocation submitted to the Contact Person(s) listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE: I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____
If this Consent is signed by a personal representative on behalf of a patient complete the following:

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____

Date of Birth: _____

Address: _____

City, State, Zip: _____

Phone Number: _____

I authorize the release of the following:

- □ Panoramic of Full Mouth X-rays- within past 5 years
- □ Bitewing or Periapical X-rays- within past 12 months
- □ Other X-rays
  Specify which: _____
- □ Dental Records
- □ Medical Records pertinent to upcoming dental appointment

Release this information from:

Name: _____

Address: _____

City, State, Zip: _____

Phone Number: _____ Fax: _____

Send this information to:

Name: Progressive Dental Group

Address: 1617 183rd Street SE, Suite 2 Mill Creek WA 98012

Phone Number: 425-368-0608 Fax: 425-368-0692

Email: info@progressivedentalnw.com

Patient Signature: _____ Date: _____