Rachel Mahoney, DMD
21727 76th Ave West • Suite G
Edmonds, WA 98026
www.MahoneyFamilyDentistry.com

MAHONEY
Family Dentistry

Office (425) 967-7272
Fax: (425) 967-7262

Thank you for trusting your child with our office. In order to serve he or she properly, please answer all questions on BOTH sides, so that we may diagnose their oral health as accurately as possible. All information will be kept strictly confidential.

CHILD'S NAME_____PREFERRED NAME _____

❑ Male ❑ Female Birthdate_____/_____/_____ Age_____Home Phone No. (_____)_____

Father's Name_____ SSN_____/_____/ _____ Birthdate_____/_____/ _____

Mailing Address_____ City_____ State____ ZipCode _____

Home Phone No. (_____) _____ Work Phone No. (_____) _____Cell Phone No. (_____)_____

Email_____ **Best number to contact you?** ❑ Home ❑ Cell ❑ Work

Father's Occupation_____Employer_____

❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Separated* ❑ *Widowed*

Mother's Name_____ SSN_____/_____/ _____Birthdate_____/_____/ _____

Mailing Address_____ City_____State____ ZipCode _____

Home Phone No. (_____) _____ Work Phone No. (_____) _____Cell Phone No. (_____)_____

Email_____ **Best number to contact you?** ❑ Home ❑ Cell ❑ Work

Mother's Occupation_____Employer_____

❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Separated* ❑ *Widowed*

With whom does this child reside? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

❑ Cash ❑ Check ❑ Bankcard

Person responsible for this child's account:_____Phone No. (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

Primary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co._____Group#_____
Insurance Phone No. _____
Employee's SSN _____
Subscriber D.O.B. _____

Secondary Dental Insurance

Employee _____
Relationship to Patient _____
Employer _____
Insurance Co._____Group#_____
Insurance Phone No. _____
Employee's SSN _____
Subscriber D.O.B. _____

I have been given and understand Mahoney Family Dentistry HIPPA Notices of Privacy Act.

Signature_____Date _____

(Turn Page Over)

Dental History

Is this your child's first dental visit? ❑ Yes ❑ No
Date of last dental visit _____
Previous Dentist's Name and Location _____
_____
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Does your child feel nervous about having dental treatment? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls/Blows/Chips/etc.? ❑ Yes ❑ No
Does your child take antibiotics for a health condition before each dental visit? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets or water? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Health History

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized or seen a Medical Doctor in the past 2 years? ❑ Yes ❑ No
If so, for what condition? _____
_____

Does your child have a personal Physician? ❑ Yes ❑ No
Physician's Name: _____
Date of last visit: _____
Reason for visit: _____

Is your child currently taking any prescriptions, over the counter drugs or herbal supplements? ❑ Yes ❑ No
If so, please list and include the reason for taking:
_____
_____
_____

Please list any serious medical condition(s) that your child currently has or has had in the past: _____
_____
_____
_____

Please Check any of the following which your child has now or has had in the past.

- ❑ **No medical conditions**
- ❑ Angina Pectoris (Chest Pain)
- ❑ Heart Disease/Attack/Stroke
- ❑ Heart Failure
- ❑ High/Low Blood Pressure
- ❑ Congenital Heart Defect
- ❑ Heart murmur/Rheumatic Fever
- ❑ Heart Surgery
- ❑ Heart Pacemaker
- ❑ Artificial Heart Valve
- ❑ Diabetes, Type I ❑ II ❑
- ❑ Blood Transfusion/Anemia
- ❑ Sickle Cell Disease
- ❑ Bruise Easily
- ❑ Hemophilia/Blood Disorder
- ❑ Liver Disease/Yellow Jaundice
- ❑ Kidney Failure/Dysfunction
- ❑ Thyroid Disease/Condition
- ❑ Ulcers
- ❑ Glaucoma
- ❑ Cosmetic surgery_____
- ❑ Chemotherapy for Cancer
- ❑ X-ray Treatment for Cancer
- ❑ Tuberculoses (TB)
- ❑ Arthritis/Rheumatism/Lupus
- ❑ Cortisone Medicine/Steroids
- ❑ Venereal Disease/STDs
- ❑ A.I.D.S./H.I.V.
- ❑ Hepatitis: A, B, C
- ❑ Frequent Headaches
- ❑ Artificial Joints (Hip, Knee, etc.)
- ❑ Canker Sores/Cold Sores
- ❑ Fainting/Dizzy Spells
- ❑ Epilepsy/Seizures
- ❑ Hay Fever/Sinus Trouble
- ❑ Allergies/Hives
- ❑ Shingles
- ❑ Anxiety Disorder
- ❑ Psychiatric Treatment
- ❑ Drug/Alcohol Addiction
- ❑ Emphysema/Asthma
- ❑ Depressed Immune System
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ Other_____

Are you allergic to or have you reacted adversely to any of the following?

Please check any that apply.

❑ Aspirin ❑ Codeine ❑ Demerol ❑ Percodan ❑ Valium ❑ Sulfa ❑ Nitrous Oxide ❑ Penicillin ❑ Erythromycin ❑ Tetracycline ❑ Other Antibiotics ❑ Latex ❑ Metals/Jewelry ❑ Local Anesthetic

*List any other allergies here:*_____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Outside of child's home)

Name_____**Home Phone No.**(____)_____**Work Phone No.** (____)_____

Relationship to Patient_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Parent/Guardian Signature _____**Date**_____

Doctor Signature _____**Date**_____

Update Record

Date	Initial

SUBMIT

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- Patient Financial Policy -

In the interest of good communication and our continued commitment to provide the highest quality of dental care available to all of our patients, we have established a Patient Financial Policy. It is our hope that this policy will facilitate open communication between us and help avoid potential misunderstandings, allowing you to always make the best choices related to your care.

We are committed to support you in understanding your dental health, and will always present you with the best dental solution possible to treat your personal situation. To make these services comfortably affordable we are pleased to offer you the following payment options. Please select one.

- ❑ Cash or Debit Card
- ❑ Visa & MasterCard
- ❑ Payment Plan – patient financing upon approval

We will, as a courtesy, process your insurance benefits in our office. All questions regarding your insurance benefits must be addressed to your insurance carrier.

I agree that I am fully responsible for the total payment of all procedures performed in this office – this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at time of service for all services rendered. I understand that all services are due to be paid within ninety (90) days of date of service, regardless of whether or not my insurance benefits have been received. One percent (1%) per month interest, twelve percent (12%) per year will be charged on accounts 90 days from treatment date. I also understand that should credit be extended to me by this dental office, a credit check will be made through TRW or other credit services and I authorize release of all financial data.

Please make your questions and concerns known to our Accounts Manager who is happy to discuss this policy and ensure that you have an outstanding experience.

Signature (responsible party) Date

P 425.967.7272 F 425.967.7262

info@mahoneyfamilydentistry.com

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SUBMIT

STATEMENT OF PRIVACY PRACTICES

Our office is 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 principal 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 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 to anyone – even family members – 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 of 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 Health 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 Health 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 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. You have a right to request and we will honor you written authorization to withhold disclosure to your dental insurance carrier for all services for which you have made full out-of-pocket payment.

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 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.

Please ask if you have any questions about your privacy rights or the protection of your health information.

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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 Mahoney Family Dentistry. 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.

Mahoney Family Dentistry 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 revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed 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 persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY	☐	**YES**	☐	**NO**
SPOUSE ONLY	☐	**YES**	☐	**NO**
OTHER (***PLEASE SPECIFY***):	☐	**YES**	☐	**NO**

_____ _____

Name of Patient or Personal Representative **Signature of Patient** or Personal Representative

_____ _____

Date Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement 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):

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