

MelissaLeeDDS

Melissa A. Lee, DDS
9714 3rd Ave NE, Suite 200
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T (206)523-7600 F (206)524-2711
www.melissaleedds.com

PATIENT REGISTRATION

Welcome to our office. We appreciate the confidence you place in us to provide quality dental care. To assist us in serving you, please complete the following form. All information is kept strictly confidential.

PLEASE PRINT

Date _____

Who may we thank for referring you to our office? _____

Last Name _____ First Name _____ Middle _____

Preferred Name _____ Date of Birth _____ Sex _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Billing Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Preferred Contact Method _____ SS# _____

Employer _____

Occupation _____ Full or Part time _____

Marital Status: Married Partner Single Divorced Separated

Name of Spouse _____ Date of Birth _____

Spouse's Employer _____ Spouse's Phone _____

Emergency Contact and Phone _____

Preferred Pharmacy Info _____

Family Members Who Are Patients Here _____

RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Phone _____ Employer _____

PRIMARY INSURANCE INFORMATION

Policy Holder (Subscriber) _____

SS# _____ Relationship to Patient: Self Spouse Child Other

Date of Birth _____ Employer _____

Dental Insurance Company _____

Policy #/Group #/Patient ID # _____

SECONDARY INSURANCE INFORMATION

Policy Holder (Subscriber) _____

SS# _____ Relationship to Patient: Self Spouse Child Other

Date of Birth _____ Employer _____

Dental Insurance Company _____

Policy #/Group #/Patient ID # _____

I have completed this form completely to the best of my knowledge and certify that I am the patient or agent of the patient authorized to furnish the information requested. I understand that although I may have some type of dental insurance coverage, I am responsible for payment of services.

Signature _____ Date _____



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HEALTH HISTORY

Although our dental team primarily treats the area in and around your mouth, it is important for us to know about your overall health. Medical conditions or medications that you may be taking could have an important relationship with the dentistry you receive. Thank you for answering the following questions. All information is kept strictly confidential.

DENTAL HEALTH HISTORY

Name _____

Previous dentist _____ City _____

How long _____ Date of last checkup and cleaning _____

Reason for today's visit _____

How often do you brush? _____ Floss? _____ See a dentist? _____

What, if anything, would you change about your teeth? _____

Do you wear a nightguard? _____ Are you a habitual gum or ice chewer? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

| | YES | NO | | YES | NO |
|-------------------------------------|-----------------------|-----------------------|---------------------------------------|-----------------------|-----------------------|
| Anxiety about dental treatment | <input type="radio"/> | <input type="radio"/> | Orofacial (mouth/face) pain | <input type="radio"/> | <input type="radio"/> |
| Problems with past dental treatment | <input type="radio"/> | <input type="radio"/> | Head/Neck injury or radiation | <input type="radio"/> | <input type="radio"/> |
| Wear dentures | <input type="radio"/> | <input type="radio"/> | Lip/mouth sores that are slow to heal | <input type="radio"/> | <input type="radio"/> |
| Difficulty chewing your food | <input type="radio"/> | <input type="radio"/> | Problems after a tooth extraction | <input type="radio"/> | <input type="radio"/> |
| Bleeding gums | <input type="radio"/> | <input type="radio"/> | Periodontal Disease | <input type="radio"/> | <input type="radio"/> |
| Sore or sensitive teeth | <input type="radio"/> | <input type="radio"/> | Deep cleaning (root planing) | <input type="radio"/> | <input type="radio"/> |
| Grind or clench your teeth | <input type="radio"/> | <input type="radio"/> | Periodontal Treatment (gum grafts) | <input type="radio"/> | <input type="radio"/> |
| | YES | NO | | YES | NO |
| Difficulty opening | <input type="radio"/> | <input type="radio"/> | Oral Surgery | <input type="radio"/> | <input type="radio"/> |
| Temporomandibular disorder (TMD) | <input type="radio"/> | <input type="radio"/> | Orthodontic Treatment | <input type="radio"/> | <input type="radio"/> |

MEDICAL HISTORY

Physician's name _____ Type _____ How long? _____

Office Address _____ Phone _____

Please list all medications that you currently take _____

Do you require premedication (antibiotics) before dental treatment? _____

If yes, what? _____

Do you use tobacco? _____ If so, what type? _____

How much? _____ How long? _____

Do you consume alcohol? _____ If so, how much? _____

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING:

| | YES | NO | | YES | NO |
|--|-----------------------|-----------------------|--|-----------------------|-----------------------|
| Hospitalization for illness or surgery | <input type="radio"/> | <input type="radio"/> | Blood transfusion | <input type="radio"/> | <input type="radio"/> |
| Heart trouble/disease | <input type="radio"/> | <input type="radio"/> | Ulcers | <input type="radio"/> | <input type="radio"/> |
| Heart attack or failure | <input type="radio"/> | <input type="radio"/> | Significant weight gain or loss | <input type="radio"/> | <input type="radio"/> |
| Chest pains | <input type="radio"/> | <input type="radio"/> | Special diet | <input type="radio"/> | <input type="radio"/> |
| Shortness of breath | <input type="radio"/> | <input type="radio"/> | Intestinal problems | <input type="radio"/> | <input type="radio"/> |
| Heart valve problems/artificial valve | <input type="radio"/> | <input type="radio"/> | Kidney disease or bladder problems | <input type="radio"/> | <input type="radio"/> |
| Heart murmur | <input type="radio"/> | <input type="radio"/> | Arthritis | <input type="radio"/> | <input type="radio"/> |
| Rheumatic fever | <input type="radio"/> | <input type="radio"/> | Back or neck pain | <input type="radio"/> | <input type="radio"/> |
| Pacemaker | <input type="radio"/> | <input type="radio"/> | Joint replacement/pin placement | <input type="radio"/> | <input type="radio"/> |
| High blood pressure | <input type="radio"/> | <input type="radio"/> | Fainting spells, seizures, or epilepsy | <input type="radio"/> | <input type="radio"/> |
| Low blood pressure | <input type="radio"/> | <input type="radio"/> | Frequent or severe headaches | <input type="radio"/> | <input type="radio"/> |
| Stroke | <input type="radio"/> | <input type="radio"/> | Thyroid or parathyroid disorders | <input type="radio"/> | <input type="radio"/> |
| Easy bruising | <input type="radio"/> | <input type="radio"/> | Persistent cough or swollen glands | <input type="radio"/> | <input type="radio"/> |

| | YES | NO | | YES | NO |
|---------------------------------|-----------------------|-----------------------|----------------------------------|-----------------------|-----------------------|
| Abnormal bleeding | <input type="radio"/> | <input type="radio"/> | Hepatitis (indicate type) | <input type="radio"/> | <input type="radio"/> |
| Anemia or other blood disorders | <input type="radio"/> | <input type="radio"/> | Jaundice | <input type="radio"/> | <input type="radio"/> |
| Liver disease | <input type="radio"/> | <input type="radio"/> | Sinus problems | <input type="radio"/> | <input type="radio"/> |
| Diabetes | <input type="radio"/> | <input type="radio"/> | Emphysema | <input type="radio"/> | <input type="radio"/> |
| Frequent urination | <input type="radio"/> | <input type="radio"/> | Emotional problems or tension | <input type="radio"/> | <input type="radio"/> |
| Frequent thirst or dry mouth | <input type="radio"/> | <input type="radio"/> | Psychiatric treatment | <input type="radio"/> | <input type="radio"/> |
| Taken Phen-Fen | <input type="radio"/> | <input type="radio"/> | History of alcohol or drug abuse | <input type="radio"/> | <input type="radio"/> |
| Tuberculosis | <input type="radio"/> | <input type="radio"/> | History of head injury | <input type="radio"/> | <input type="radio"/> |

| | | | | | |
|-----------------------------|-----------------------|-----------------------|------------------------------|-----------------------|-----------------------|
| Scarlet Fever | <input type="radio"/> | <input type="radio"/> | Cancer or Tumor | <input type="radio"/> | <input type="radio"/> |
| Glaucoma | <input type="radio"/> | <input type="radio"/> | Radiation treatment | <input type="radio"/> | <input type="radio"/> |
| Wear contact lenses | <input type="radio"/> | <input type="radio"/> | Prostate disorders (if male) | <input type="radio"/> | <input type="radio"/> |
| Asthma | <input type="radio"/> | <input type="radio"/> | HIV positive | <input type="radio"/> | <input type="radio"/> |
| Hives, skin rash, hay fever | <input type="radio"/> | <input type="radio"/> | AIDS | <input type="radio"/> | <input type="radio"/> |

ARE YOU ALLERGIC OR REACTED ADVERSELY TO ANY OF THE FOLLOWING:

| | YES | NO | | YES | NO |
|---------------------------------|-----------------------|-----------------------|----------------------|-----------------------|-----------------------|
| Local Anesthetics ("novocaine") | <input type="radio"/> | <input type="radio"/> | Metal | <input type="radio"/> | <input type="radio"/> |
| Penicillin or other antibiotics | <input type="radio"/> | <input type="radio"/> | Latex | <input type="radio"/> | <input type="radio"/> |
| Sulfa drugs | <input type="radio"/> | <input type="radio"/> | Aspirin | <input type="radio"/> | <input type="radio"/> |
| Tetracycline | <input type="radio"/> | <input type="radio"/> | Acetaminophen | <input type="radio"/> | <input type="radio"/> |
| Sedatives or sleeping pills | <input type="radio"/> | <input type="radio"/> | Ibuprofen | <input type="radio"/> | <input type="radio"/> |
| Codeine or other narcotic | <input type="radio"/> | <input type="radio"/> | Any other medication | <input type="radio"/> | <input type="radio"/> |

DURING THE PAST 12 MONTHS, HAVE YOU TAKEN ANY OF THE FOLLOWING:

| | YES | NO | | YES | NO |
|-------------------------------------|-----------------------|-----------------------|---------------------------------|-----------------------|-----------------------|
| Antibiotics or sulfa drugs | <input type="radio"/> | <input type="radio"/> | Anticoagulants (e.g., coumadin) | <input type="radio"/> | <input type="radio"/> |
| High Blood Pressure Medication | <input type="radio"/> | <input type="radio"/> | Tranquilizers | <input type="radio"/> | <input type="radio"/> |
| Insulin, Orinase, or similar | <input type="radio"/> | <input type="radio"/> | Aspirin | <input type="radio"/> | <input type="radio"/> |
| Digitalis or other heart medication | <input type="radio"/> | <input type="radio"/> | Nitroglycerin | <input type="radio"/> | <input type="radio"/> |
| | YES | NO | | YES | NO |
| Cortisone or other steroids | <input type="radio"/> | <input type="radio"/> | Natural remedies | <input type="radio"/> | <input type="radio"/> |
| Vitamin Supplements | <input type="radio"/> | <input type="radio"/> | Nonprescription drugs | <input type="radio"/> | <input type="radio"/> |

WOMEN:

| | YES | NO | | YES | NO |
|------------------|-----------------------|-----------------------|----------------------------|-----------------------|-----------------------|
| Are you pregnant | <input type="radio"/> | <input type="radio"/> | Taking oral contraceptives | <input type="radio"/> | <input type="radio"/> |
| Nursing | <input type="radio"/> | <input type="radio"/> | Reached Menopause | <input type="radio"/> | <input type="radio"/> |

Do you have any disease, condition, or problem not listed previously that we should know about? If so, please describe in detail _____

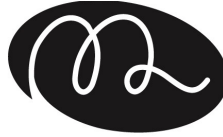
To the best of my knowledge, the questions on this form have been adequately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental staff of any changes in my health history.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____

DATE _____

DENTAL STAFF INITIALS _____ DATE _____

DENTIST'S INITIALS _____ DATE _____



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Financial Agreement

As a courtesy to our patients, we try to provide an accurate as possible ESTIMATE for your dental work based on information provided to us by your insurance company. Any actual insurance benefit is *not guaranteed* as they are subject to review by your insurance company.

It is ultimately your responsibility to know your eligibility, what your insurance covers (and what it does not), and any policy limits you have in relation to coverage. If for ANY reason your insurance does not pay 100% for your dental work, *you are responsible for any remaining balance on your account*, regardless of any estimates we have provided. Your insurance company has the final say on what they will cover, therefore we cannot take responsibility for any incorrect information they have provided us. Should you have any questions regarding your coverage, we recommend contacting your insurance company directly.

Please note that we require payment at the time of service. Unpaid balances are subject to a \$25 statement fee.

Missed or cancelled appointments with less than 48 hours notice are subject to a \$50 service charge.

I _____ have read and understand the above information.

Patient Signature

Date

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Melissa A. Lee, DDS
9714 3rd Ave NE, Suite 200
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206.523.7600 t
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My signature confirms that I have been informed of my rights to privacy regarding my protected health information under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number a health care providers who my be involved in treatment directly and indirectly

Obtain payment from third party payers for my health care services

Conduct normal health care operations such as quality assessment and improvement activities

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care options.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

You may share my information (relevant to the operations of our health care services) with the following

person(s): _____

FOR OFFICE USE ONLY:

We were unable to obtain the patient's written acknowledgment of our *Notice of Privacy Practices* due to the following reason:

- The patient refused to sign
- Communication barriers
- Emergency Situation
- Other

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MY 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 information used or disclosed to us in any form, whether electronically, on paper, or orally, to 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 law, 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 record 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 health care providers or specialists involved in the continuation of your care.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection, and utilization review. For example, we may disclose treatment information 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 used for training purposes or quality assessment.

Unless you request otherwise, we may use or disclose health information to a family member, friend, personal representative, or other individual to the extent necessary to help with your health care or with payment for your health care. In the event of an emergency or your incapacity, we will use our professional judgment in disclosing only the protected health information necessary to facilitate needed care. In addition, we may use your confidential information to remind you of appointments by sending reminder postcards and/or leaving messages at home and/or work. Your protected health information may also be used by our office to recommend treatment alternatives or to provide you with information about health related benefits and services that may be of interest to you. In addition, we may disclose your health information for public health oversight activities, judicial or administrative proceedings, in response to a subpoena or court order, to military authorities of Armed Forces personnel, to federal officials for lawful intelligence, counterintelligence, and other national security activities, to correctional institutions or law enforcement officials, and/or to report suspected abuse, neglect, or domestic violence. 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 may 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, with limited exceptions. A reasonable fee may apply.
- The right to request an amendment to your protected health information. We may deny your request in certain situations.
- The right to receive an accounting of disclosures of protected health information made outside of treatment, payment, or health care operation, or based on your previous authorization.
- The right to obtain a paper copy of this notice from us upon request, even if you have agreed to receive the notice electronically.

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 January 1, 2007 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.

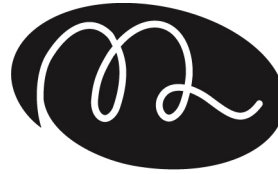
You have the right to file a formal, written complaint with us at the address below, or with the Department of Health & Human Services, Office of Civil Rights, in the event you feel your privacy rights have been violated. We will not retaliate against you for filing a complaint.

For more information about our privacy practices, please contact:

Melissa A. Lee
Melissa A. Lee, DDS, PLLC
9714 3rd Ave NE, Suite 200
Seattle, WA 98115

For more information about HIPAA or to file a complaint:

US Department of Health & Human Services
Office of Civil Rights
200 Independence Ave SW
Washington, DC 20201
877-696-6775



MelissaLeeDDS

HEALTH HISTORY UPDATE

PATIENT NAME _____ TODAY'S DATE _____

CURRENT ADDRESS _____

CONTACT PHONE NUMBER _____ EMAIL _____

ARE YOU BEING TREATED FOR AN ILLNESS OR HAD SURGERY IN THE LAST YEAR? YES NO

If yes, please explain _____

DATE OF LAST PHYSICAL/WELLNESS EXAM _____

DO YOU REQUIRE PREMEDICATION (ANTIBIOTICS) PRIOR TO DENTAL TREATMENT AS INSTRUCTED BY A PHYSICIAN? YES NO If yes, for what condition? _____

PLEASE LIST ALL MEDICATIONS YOU TAKE INCLUDING OVER THE COUNTER/HERBAL REMEDIES _____

PLEASE LIST ALL ALLERGIES _____

ANY REACTIONS TO ANESTHESIA? YES NO

ARE YOU OR IS THERE A CHANCE YOU ARE PREGNANT? YES NO

DO YOU USE ALCOHOL? YES NO TOBACCO PRODUCTS (including vaping)? YES NO

If yes, how much and for how long? _____

To the best of my knowledge, the questions on this form have been answered correctly. I understand that providing incorrect or false information can adversely affect my health.

SIGNATURE OF PATIENT, PARENT, OR LEGAL GUARDIAN _____