



*BEFORE Filling Out Your Registration Forms
Please Read This Information Sheet*

In accordance with the law, we require a government issued photo identification document, and we take a digital photo to verify and protect your identity as well as facilitate accurate personal records.

Your first visit with us is an examination and x ray appointment.


→ We **DO NOT** provide cleanings on the first visit for adults age 18 and older ←
Doctors provide all treatment along with our registered dental assistants.
We do not have hygienists on staff.

To avoid prolonged wait times for all patients, we may need to limit the number of issues addressed in a single visit. Please prioritize with your doctor, which issues are of top importance to be discussed at your visit. We can assist you in scheduling additional appointments as needed.

To reserve appointments for dental treatment over \$200.00, we require a deposit of \$100.00. It is refundable up to 2 business days prior to the reserved appointment.

For our patients with dental insurance, the estimated insurance payments are not a guarantee of payment and your co insurance payment and or deductibles are due at the time of service.

If you do not have insurance, please take a brochure about our 8 TO 8 Dental Membership Plan, saving you 30 – 50 % on dental treatment.

Out of respect for the Doctors and Patients, please turn off or silence your cell phone 



Patient Registration

Date _____

Patients Name: _____

If Patient is MINOR, Responsible Party: _____

Preferred Name: _____

Relationship to minor: _____

Child Single Married Other

Name of Spouse/Parent: _____

Birthdate/Age: _____

Birthdate/Age: _____

Social Security #: _____

Social Security#: _____

Address: _____

Address: _____

City, State, Zip Code: _____

City, State, Zip Code: _____

E-mail: _____

Email: _____

Home Phone: _____

Home Phone: _____

Work Phone: _____

Work Phone: _____

Cell Phone: _____

Cell Phone: _____

Occupation: _____

Occupation: _____

Employer: _____

Employer: _____

Work Address: _____

Work Address: _____

If a college student please list name of school: _____

Name, Address, and Phone of relative NOT living with you: _____

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

Drive By Walk By Friend Family Other _____

Are any of your family members patients here? Yes No If yes, name(s) _____

Insurance 1st Coverage

Insurance 2nd Coverage

Subscribers Name: _____

Subscribers Name: _____

SS/ID #: _____

SS/ID #: _____

Date of Birth: _____ Relationship to Patient : _____

Date of Birth _____ Relationship to Patient _____

Name of Employer: _____

Name of Employer: _____

Insurance Co: _____

Insurance Co: _____

Group/Policy #: _____

Group/Policy #: _____

Insurance Co Phone: _____

Insurance Co Phone: _____

Patient Name: _____

Date: _____

Physician Name: _____

Phone : _____

Have you been advised to take antibiotics (like amoxicillin,etc.) before a dental procedure? Yes No

Are you seeing a physician for a recent or on going medical condition? Yes No

Explain: _____

Have you been hospitalized in the past year? Yes No

Explain: _____

Women:

<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; text-align:center;">Y</td> <td style="width:20px; text-align:center;">N</td> <td style="width:480px;">Are you pregnant Due Date: _____</td> </tr> </table>	Y	N	Are you pregnant Due Date: _____	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; text-align:center;">Y</td> <td style="width:20px; text-align:center;">N</td> <td style="width:480px;">Are you Nursing</td> </tr> </table>	Y	N	Are you Nursing	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:20px; text-align:center;">Y</td> <td style="width:20px; text-align:center;">N</td> <td style="width:480px;">Are you taking Hormones</td> </tr> </table>	Y	N	Are you taking Hormones
Y	N	Are you pregnant Due Date: _____									
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PLEASE CIRCLE YES (Y) OR NO (N) TO ANY OF THE FOLLOWING THAT APPLY TO YOU:

<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>High Blood Pressure</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Low Blood Pressure</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Heart Disease</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Heart Failure</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Heart Attack</td></tr> <tr><td style="width:20px; text-align:center;"></td><td style="width:20px; text-align:center;"></td><td>When _____</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Heart Murmur</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Stroke</td></tr> <tr><td style="width:20px; text-align:center;"></td><td style="width:20px; text-align:center;"></td><td>When _____</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Angina</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Chest pain on exertion</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Congenital Heart Disease</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Pacemaker / Implanted Defibrillator</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Artificial Heart Valves</td></tr> <tr><td style="width:20px; text-align:center;"></td><td style="width:20px; text-align:center;"></td><td>When _____</td></tr> <tr><td style="width:20px; 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Y	N	Hemophilia																																																																																																																																																																																																																																																																																																													
Y	N	Leukemia																																																																																																																																																																																																																																																																																																													
Y	N	Tumors / Growths																																																																																																																																																																																																																																																																																																													
Y	N	Cancer Type _____																																																																																																																																																																																																																																																																																																													
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Y	N	Radiation treatment																																																																																																																																																																																																																																																																																																													
Y	N	Organ transplant																																																																																																																																																																																																																																																																																																													
		When _____																																																																																																																																																																																																																																																																																																													
Y	N	Glaucoma																																																																																																																																																																																																																																																																																																													
Y	N	Wear contact lenses																																																																																																																																																																																																																																																																																																													
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Y	N	Gastrointestinal disorders																																																																																																																																																																																																																																																																																																													
Y	N	Acid Reflux																																																																																																																																																																																																																																																																																																													
Y	N	Ulcers																																																																																																																																																																																																																																																																																																													
Y	N	Heartburn																																																																																																																																																																																																																																																																																																													
Y	N	Eating Disorder																																																																																																																																																																																																																																																																																																													
Y	N	Drastic Weight gain or loss																																																																																																																																																																																																																																																																																																													
Y	N	Special Diet																																																																																																																																																																																																																																																																																																													
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Y	N	Hypoglycemia																																																																																																																																																																																																																																																																																																													
Y	N	Hepatitis A (infectious)																																																																																																																																																																																																																																																																																																													
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Y	N	Hepatitis C																																																																																																																																																																																																																																																																																																													
Y	N	Kidney or bladder disease																																																																																																																																																																																																																																																																																																													
Y	N	Cirrhosis																																																																																																																																																																																																																																																																																																													
Y	N	Jaundice																																																																																																																																																																																																																																																																																																													
Y	N	Thyroid disease																																																																																																																																																																																																																																																																																																													
Y	N	Liver disease																																																																																																																																																																																																																																																																																																													
Y	N	Arthritis / Rheumatism																																																																																																																																																																																																																																																																																																													
Y	N	Bone Disorders																																																																																																																																																																																																																																																																																																													
Y	N	Osteoporosis																																																																																																																																																																																																																																																																																																													
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Y	N	Lupus																																																																																																																																																																																																																																																																																																													
Y	N	Sjogren's syndrome																																																																																																																																																																																																																																																																																																													
Y	N	Skin rashes or Hives																																																																																																																																																																																																																																																																																																													
Y	N	Skin problems																																																																																																																																																																																																																																																																																																													
Y	N	Chronic sinus trouble																																																																																																																																																																																																																																																																																																													
Y	N	Asthma																																																																																																																																																																																																																																																																																																													
Y	N	Hay Fever / Allergies																																																																																																																																																																																																																																																																																																													
Y	N	Respiratory problem																																																																																																																																																																																																																																																																																																													
Y	N	Emphysema																																																																																																																																																																																																																																																																																																													
Y	N	Tuberculosis																																																																																																																																																																																																																																																																																																													
Y	N	Persistent cough																																																																																																																																																																																																																																																																																																													
Y	N	Cold sores / Fever Blisters																																																																																																																																																																																																																																																																																																													
Y	N	Herpes																																																																																																																																																																																																																																																																																																													
Y	N	Sexually transmitted disease																																																																																																																																																																																																																																																																																																													
Y	N	°AIDS °HIV °ARC																																																																																																																																																																																																																																																																																																													
Y	N	Epilepsy / Seizures																																																																																																																																																																																																																																																																																																													
Y	N	Alcoholism																																																																																																																																																																																																																																																																																																													
Y	N	Drug Abuse																																																																																																																																																																																																																																																																																																													
		°Narcotics °Methamphetamine																																																																																																																																																																																																																																																																																																													
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Y	N	Dizziness																																																																																																																																																																																																																																																																																																													
Y	N	Fainting spells																																																																																																																																																																																																																																																																																																													
Y	N	Fibromyalgia																																																																																																																																																																																																																																																																																																													
Y	N	Pain in Jaw Joints																																																																																																																																																																																																																																																																																																													
Y	N	Frequent / Severe Headaches																																																																																																																																																																																																																																																																																																													
Y	N	Migraine headaches																																																																																																																																																																																																																																																																																																													
Y	N	Back or neck pain																																																																																																																																																																																																																																																																																																													
Y	N	Head injuries																																																																																																																																																																																																																																																																																																													
Y	N	Psychiatric Treatment																																																																																																																																																																																																																																																																																																													
Y	N	Depression																																																																																																																																																																																																																																																																																																													
Y	N	Alzheimer's disease																																																																																																																																																																																																																																																																																																													
Y	N	Nervous disorder																																																																																																																																																																																																																																																																																																													
Y	N	Parkinson's disease																																																																																																																																																																																																																																																																																																													
Y	N	Hyper Activity																																																																																																																																																																																																																																																																																																													
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Y	N	Metal / Jewelry allergy																																																																																																																																																																																																																																																																																																													
Y	N	Latex Allergy																																																																																																																																																																																																																																																																																																													

ARE YOU TAKING OR HAVE YOU TAKEN THE FOLLOWING IN THE PAST 6 MONTHS: CIRCLE YES (Y) or NO (N)

<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Bisphosphonates or medicine for osteoporosis: (Fosemax, Aredia, Zometa, etc. Other: _____)</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Have you ever taken any diet pills? (Fen-phen, Phentermine, Redux, Pondimin)</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Antibiotics</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Antidepressants (Prozac, Zoloft, etc.)</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Blood Pressure Medication</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Blood Thinners (Coumadin, Plavix, Aspirin, etc.)</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Steroids, Cortisone, Prednisone, Hydrocortisone</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Hormones (birth control pills, estrogen)</td></tr> </table>	Y	N	Bisphosphonates or medicine for osteoporosis: (Fosemax, Aredia, Zometa, etc. Other: _____)	Y	N	Have you ever taken any diet pills? (Fen-phen, Phentermine, Redux, Pondimin)	Y	N	Antibiotics	Y	N	Antidepressants (Prozac, Zoloft, etc.)	Y	N	Blood Pressure Medication	Y	N	Blood Thinners (Coumadin, Plavix, Aspirin, etc.)	Y	N	Steroids, Cortisone, Prednisone, Hydrocortisone	Y	N	Hormones (birth control pills, estrogen)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Insulin</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Muscle Relaxants</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Medicine for Heart Problems</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Nitroglycerin</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Prescription Pain Medicine</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Thyroid Medicine</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Tranquilizers (Valium, Xanax, Klonopin, Risperdal, Haldol, etc.)</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Natural Remedies/ Herbs</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Supplements</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Other</td></tr> </table>	Y	N	Insulin	Y	N	Muscle Relaxants	Y	N	Medicine for Heart Problems	Y	N	Nitroglycerin	Y	N	Prescription Pain Medicine	Y	N	Thyroid Medicine	Y	N	Tranquilizers (Valium, Xanax, Klonopin, Risperdal, Haldol, etc.)	Y	N	Natural Remedies/ Herbs	Y	N	Supplements	Y	N	Other
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Y	N	Other																																																					

HAVE YOU HAD AN ALLERGY OR ADVERSE REACTION TO ANY OF THE FOLLOWING: CIRCLE YES (Y) or NO (N)

<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Aspirin, Acetaminophen, or Ibuprofen</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Barbiturates, sedatives, or sleeping pills</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Codeine, Demerol, or other narcotics</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Latex or Rubber Dam</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Local Anesthetics (Novacaine)</td></tr> </table>	Y	N	Aspirin, Acetaminophen, or Ibuprofen	Y	N	Barbiturates, sedatives, or sleeping pills	Y	N	Codeine, Demerol, or other narcotics	Y	N	Latex or Rubber Dam	Y	N	Local Anesthetics (Novacaine)	<table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Nitrous Oxide</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Penicillin or antibiotics</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Reaction to Metals/Jewelry</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Sulfa Drugs</td></tr> <tr><td style="width:20px; text-align:center;">Y</td><td style="width:20px; text-align:center;">N</td><td>Other</td></tr> </table>	Y	N	Nitrous Oxide	Y	N	Penicillin or antibiotics	Y	N	Reaction to Metals/Jewelry	Y	N	Sulfa Drugs	Y	N	Other
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Y	N	Sulfa Drugs																													
Y	N	Other																													

LIST ALL MEDICATIONS, SUPPLEMENTS AND / OR HERBS YOU ARE CURRENTLY TAKING:

Do you need and / or want a referral for a Naturopathic Provider or an Acupuncture Provider? _____

DENTAL HISTORY

REASON FOR YOUR VISIT: _____

When was your last visit to a dentist? _____ Reason: _____

Previous Dentist: _____ Last x ray date: _____

Reason for not returning to your previous dentist: _____

When was your last teeth cleaning? _____ How many cleanings do you have per year? _____

How often do you brush? _____ How often do you floss? _____

DO YOU HAVE OR HAVE YOU EVER HAD : CHECK ALL THAT ARE APPLY TO YOU

<input type="checkbox"/> Y	<input type="checkbox"/> N	Food caught between teeth	<input type="checkbox"/> Y	<input type="checkbox"/> N	Trouble opening or closing your jaw	<input type="checkbox"/> Y	<input type="checkbox"/> N	Reaction to "Novacaine"
<input type="checkbox"/> Y	<input type="checkbox"/> N	Sore or sensitive teeth	<input type="checkbox"/> Y	<input type="checkbox"/> N	Gums red, swollen, or tender	<input type="checkbox"/> Y	<input type="checkbox"/> N	Trouble getting numb
<input type="checkbox"/> Y	<input type="checkbox"/> N	Jaw pain	<input type="checkbox"/> Y	<input type="checkbox"/> N	Gums pulling away from your teeth	<input type="checkbox"/> Y	<input type="checkbox"/> N	Trouble staying numb
<input type="checkbox"/> Y	<input type="checkbox"/> N	Grind or clench teeth	<input type="checkbox"/> Y	<input type="checkbox"/> N	Loose teeth or teeth separating	<input type="checkbox"/> Y	<input type="checkbox"/> N	Dental anxiety or fear
<input type="checkbox"/> Y	<input type="checkbox"/> N	Difficulty chewing	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you see pus when gums are pressed	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you smoke
<input type="checkbox"/> Y	<input type="checkbox"/> N	Periodontal (Gum) disease	<input type="checkbox"/> Y	<input type="checkbox"/> N	Changes in the way your teeth fit together	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you chew tobacco
<input type="checkbox"/> Y	<input type="checkbox"/> N	Bad Breath	<input type="checkbox"/> Y	<input type="checkbox"/> N	Sores on lips/ mouth slow to heal	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you drink soda in "excess"
<input type="checkbox"/> Y	<input type="checkbox"/> N	Gums bleed when brushing	<input type="checkbox"/> Y	<input type="checkbox"/> N	Excessive bleeding / slow healing after extraction	<input type="checkbox"/> Y	<input type="checkbox"/> N	Do you eat sweets in "excess"

Dissatisfied with appearance of teeth _____

Anything else we should know _____

To the best of my knowledge, all of these answers are true and correct. If I ever have any changes in my health or medicines, I will inform the doctor at my next appointment.

Patient, parent, guardian or patient representatives signature

DATE

Reviewed by:

8TO 8 Dental

1418 164th Street SW #100

Lynnwood, Wa 98087

www.828dentalcare.com

425. 742. 8828



1418 164th St. SW, Suite 100
Lynnwood, WA 98087

We strive to provide the best service possible. You have choices for treatment and choices for payment.
We offer the following payment options:

Payment plans interest free through Care Credit. We can assist you with our easy application.

NO down payment. NO pre payment penalty. Extended payments available.

**Refunds for Financing are reduced by the percentage amount our office paid at the time of financing between 9.9% -14.9%. **

Pay as you go. The patient responsibility can be estimated at each appointment. We accept **cash, check, American Express, Discover, Mastercard, or Visa**. Our office uses Telecheck as our check verification system. There is \$30 charge for returned checks.

Lay away plan. You can make payments that work in your budget and schedule treatment when the credit has accumulated to equal the treatment costs.

Cancellation policy: A two (2) business day notice is required to avoid a \$100.00 late cancellation fee. It is up to the discretion of the Doctor to charge for missed or cancelled appointments.

Deposits are required to reserve appointments for treatment over \$200.00. It is applied toward your treatment costs, and is refundable up to 2 days prior to your reserved appointment.

To our minor (under 18) patients

Minor patients will be seen when they are accompanied by their parent or guardian. The parent who accompanies the minor is the one who will be financially responsible for treatment given. We will not bill a missing parent due to a divorce or any other complication. Please make arrangements before treatment so this will not be a problem.

About InsuranceWe do not guarantee insurance estimates. We gladly accept most insurances and file claims within 24 hours electronically. Once insurance has paid, any remaining balance will be billed to you. Payment is due within 30 days of billing. After 60 days from your date of service, if your insurance has not paid us, our office reserves the right to request payment in full and have you collect the insurance funds that are due you.

****Dual Insurance is not a guarantee that treatment is covered 100%****

Statements are mailed by the 20th of each month for balances after insurance claims have processed. Balances of 60 days will be subject to a finance charge of 18% APR.

Informed Consent Disclosure, Agreement, and Release of Information:

I have read the above dental financial plan and understand that I am financially responsible for the entire balance, including interest fees. If applicable, I authorize insurance benefits to be paid directly to the dentist and understand that I am financially responsible for services not covered by insurance. I further authorize the dentist to release medical or dental information or other records, including x-rays, necessary in the conduct and disposition of my case. I am also responsible for all the collection and/or attorney fees should my account become delinquent.

Signature of Patient, or Legal Guardian

Date



1418 164th St SW Suite 100, Lynnwood, WA 98087
(425)742-8828 Fax: (425)745-8828
www.8to8dentalcare.com

INSURANCE AND FINANCIAL POLICIES

If you have Insurance, please read and sign below.

We understand that billing and collection services can be confusing and to assist you in understanding our billing process, please review the following information. We take a positive and proactive approach to patient billing and collections with the goal of maximizing the benefits you deserve, and receiving payment for services we provide in the most efficient and customer sensitive manner possible.

- **Your dental insurance is a legal contract with you, your employer and the insurance company**
- **Our office is not part of that legal contract**
- **We urge you to become familiar with your plans limits, restrictions and annual maximum**

CO-PAYS AND DEDUCTIBLES: IT IS IMPOSSIBLE TO GIVE YOU A GUARANTEED QUOTE

As part of a service for you, we will verify insurance eligibility and get a general breakdown of your coverage. Prior to scheduling appointments, you will receive a written ESTIMATE outlining your treatment costs, insurance benefits, and your financial responsibility. If your insurance company requires co-pay, deductible, and / or covers only a percentage of your treatment costs, we will request payment at the time of service.

DENTAL INSURANCE BILLING: WE DO NOT GUARANTEE INSURANCE PAYMENTS

If you have supplied us with your complete and current dental insurance information, we will bill your insurance at no charge, electronically within 24 hours of the completion of your procedure, providing x-rays, charting and narratives necessary for processing. Once insurance has paid, any remaining balance will be billed to you. Payment is due within 30 days of billing.

After 60 days from your treatment, if your insurance has not paid us, our office reserves the right to request payment in full for services and let you collect the insurance funds that are due you.

Billing statements are mailed the 20th of each month and payment is due upon receipt to avoid assignment to collections.

PREVENTIVE CARE VISITS:

Prior to scheduling your check up appointments, please check that your insurance is current, and that your visit is covered. If you have new insurance, since your last visit, please notify us at the time of scheduling.

If you have questions regarding your insurance, contact your employer or insurance company directly.

I have read and agree with the above conditions.

Name of patient, parent or guardian

Date



1418 164th St. SW, Suite# 100
Lynnwood, WA 98087
Ph: (425)742-8828 Fax: (425)745-8828
www.828dental.com

I hereby instruct and direct My Insurance Company to pay by check made out and mailed to:

8 TO 8 Dental
1418 164th St. SW , Suite #100
Lynnwood, WA 98037

If my current policy prohibits direct payment to the doctor, I hereby also instruct and direct you, the Insurance Company, to make out the check to me and mail it as follows:

c/o 8 TO 8 Dental
1418 164th St. SW , Suite #100
Lynnwood, WA 98037

for the professional or medical expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

I, the Patient, authorize the Doctor to deposit checks received on my account when made out to me, the Patient.

Signature of Patient, or Legal Guardian

Date

8 TO 8 DENTAL

CONSENT FORM FOR PROTECTED HEALTH INFORMATION

I, _____ understand that by signing this consent form I am consenting to the disclosure by of my protected health information including my dental file with dental chart, doctors notes, and x-rays. I understand that my protected health information may be viewed by the employee's of 8 to 8 Dental and may be disclosed to outside counsel, experts, specialists, and their associates. I understand that I may revoke this consent at any time by giving 8 to 8 Dental written notice of my revocation. I understand that the revocation of this consent will not affect any action taken by 8 to 8 Dental in reliance on this consent before we received your revocation.

I, _____, have had full opportunity to read and consider the contents of this consent form and I understand that I am consenting to the disclosure of my protected health information to the individuals listed above.

Signature _____ Date _____

NOTICE OF CHARGES FOR THE DUPLICATION OF X-RAYS

According to the federal Health Insurance Portability and Accountability Act (HIPAA), a copy of records, including x-rays, shall be available to the patient for his or her designated representative, upon written authorization request a copy of such records, dated and signed by the patient upon reasonable notice and payment of reasonable costs.

According to Washington State Law, we must maintain original patient records for a minimum of 10 years. If you want or need your x-rays for another office, we will need to duplicate your original x-rays.

If you would like a copy of your x-rays and / or records, there is a **\$25.00 duplication fee** which must be paid prior to release of your x-rays and /or records along with a signed authorization form.

Thank you for your cooperation.

Signature _____ Date _____

8 TO 8 DENTAL
1418 164th Street SW, STE #100, Lynnwood, WA 98087
Ph. 425.742.8828 Fax 425.745.8828



General Consent

Thank you for choosing our office for your dental care. We will work with you to help you achieve excellent oral health. While recognizing the benefits of a pleasing smile and teeth that function well, you should be aware that dental treatment, like treatment of any other part of the body, has some inherent risks. These are seldom great enough to offset the benefits of treatment, but should be considered when making treatment decisions.

Benefits of dental treatment can include: relief of pain, the ability to chew properly, and the confidence and social interaction that a pleasing smile can bring. Nonetheless, there are some common risks associated with virtually any dental procedure, including:

1. **Drug or chemical, reaction.** Dental materials and medications may trigger allergic or sensitivity reactions.
2. **Long-term numbness (paresthesia)**-Local anesthetic, or its administration, while almost always adequate to allow comfortable care, can result in transient, or in rare instances, permanent numbness.
3. **Muscle or joint tenderness.** Holding one's mouth open can result in muscle or jaw joint tenderness, or in a predisposed patient, a TMJ disorder.
4. **Sensitivity in teeth or gums, infection, or bleeding.**
5. **Swallowing or inhaling small objects.**

While we follow procedural guidelines which most often lead to a clinical success, just like many other pursuits in health care, not everything turns out the way it is planned. We will do our best to assure that it does. Please feel free to ask questions in regard to all dental procedures that are recommended to you. I have read and understand that statement on this page:

Patient's Signature

Date

Patient's Signature (if minor patient)

Date



1418 164th Street SW, Ste. #100
Lynnwood, WA 98087

Acknowledgement of Receipt of Statement of Privacy Practices

I acknowledge that I have received a copy of the Statement of Privacy Practices for the office of 8 to 8 Dental. 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 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. 8 to 8 Dental 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 Practice by requesting that one be mailed to me.

Additional Disclosure Authority				
<i>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.</i>				
Any member of my immediate family		Yes		NO
Spouse only		Yes		NO
Other (please specify)		Yes		NO
I give 8 TO 8 Dental permission to leave a message regarding my dental treatment, procedures, insurance, finances and appointments on my voicemail, or with a person answering my phone at the numbers provided.	Home	Cell	Work	Other

Name of Patient Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority

Date

OFFICE USE ONLY Record of Acknowledgement Not Obtained

Provided treatment provided	YES	NO
Date Prior Treatment Provided:		
Reason for declining signature:		
Needed more time to review Statement of Privacy Practice		
Wanted to consult with another person before signing		
Unable to sign		
Reason not given		
Other (explain):		

8 to 8 Dental

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 (08/01/09), 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 to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and 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 a 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.

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 official 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).

PATIENT 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 \$25.00 to copy your health information, and for 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 your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. 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 required 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 it 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 Web site or by electronic mail (e-mail), 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.

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