PINE LAKE DENTAL CARE
FINANCIAL POLICY

We appreciate the opportunity to serve you! It is our goal for patients to clearly understand their treatment needs, as well as their financial responsibility, before treatment begins. Please read the following carefully and ask us any questions you might have.

INSURANCE

As a courtesy to our patients, we will submit insurance claims directly to your insurance carrier. We can estimate and will assist you in determining your insurance benefits**. Any patient portion is due at the time of service.** If for any reason, the estimated amount is not paid by your insurance company, **please remember that you are fully responsible for all fees** charged by this office regardless of your insurance coverage.

We encourage you to review your insurance policy in detail so that you are aware of your plan's specific benefits and maximum coverage. It is your responsibility to know your insurance coverage and to notify us of any changes that may occur.

NON-INSURED AND EMERGENCY SERVICES

Payment in full is required at the time of service.

PAYMENT OPTIONS

We accept **Visa, MasterCard, checks, and cash** for the amount due. We also offer financing through **CareCredit**. To apply for a line of credit, please contact us for more information. Courtesies are available for patients who pay in full with cash.

TWO BUSINESS DAYS NOTICE IS REQUIRED FOR RESCHEDULING APPOINTMENTS

Dr. Robertson and Dr. Phan reserve your appointment time exclusively for you. Please be considerate.

This is an agreement between Christopher C. Robertson, DDS, PS, as creditor, and the Patient/Debtor named on this form. By signing this agreement, you consent to treatment by Christopher C. Robertson, DDS, PS and his staff and agree to pay for all services that are received. In addition, you authorize Christopher C. Robertson, DDS, PS to release any necessary information requested by your insurance carrier and authorize payment directly to Christopher C. Robertson, DDS, PS for any benefits available under your insurance plan.

Patient's Name: _____

Responsible Party (If patient is under 18 years-old): _____

Signature: _____ Date: _____

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com

PINE LAKE DENTAL CARE
PATIENT AND RESPONSIBLE PARTY INFORMATION

Patient name: _____ Preferred Name: _____

Date of Birth: _____ Age: _____ Male ☐ Female ☐ Married ☐ Single ☐ Minor ☐

Home address: _____
Street and Apt # City, State Zip Code

Home telephone: _____ Work: _____ Cell:_____

(Please circle the number you would prefer for us to use to contact you.)

Email address: _____

If you provide your email address, we will enroll you in Dental Sesame - our free service for email appointment reminders and online account information. Your email address will be kept private.

Who will be responsible for the charges incurred on this account? _____

How were you referred to our office? _____

INSURANCE INFORMATION Please present insurance card if you have one

Primary Dental Insurance Company: _____

Employer: _____ Occupation: _____

Policy holder/Subscriber's Name: _____
Last First M

Patient's relationship to Subscriber: Self ☐ Spouse/Partner ☐ Child/Stepchild ☐

Subscriber's ID #: _____ Group #: _____
Subscriber's Date of Birth: _____ Subscriber's SS#: _____

Secondary Dental Insurance Company: _____

Employer: _____ Occupation: _____

Policy holder/Subscriber's Name: _____
Last First M

Patient's relationship to Subscriber: Self ☐ Spouse/Partner ☐ Child/Stepchild ☐

Subscriber's ID #: _____ Group #: _____
Subscriber's Date of Birth: _____ Subscriber's SS#: _____

I certify that the above information is true, to the best of my knowledge. If any of this information changes, I will provide that information to Pine Lake Dental Care as soon as possible. I understand that failure to provide accurate information in a timely manner may result in being billed for the full fee for any services provided to me.

_____ _____
Signature **Date**

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com

PINE LAKE DENTAL CARE
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been informed of the *Notice of Privacy Practices* for Pine Lake Dental Care, the dental office of Dr. Christopher C. Robertson, DDS, PS and Dr. Kimchi L. Phan, DDS. I have been given the right to review and receive a copy of the *Notice of Privacy Practices*. The *Notice 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 health care operations.**

We reserve the right to change practices that are described in the *Notice of Privacy Practices*. If privacy practices change, I will be offered a copy of the *revised Notice of Privacy Practices* at the time of my first visit after the changes become effective. I may also obtain a *revised Notice of Privacy Practices* by requesting that one be mailed to me.

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 operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

In addition to the allowable disclosures described in *the Notice of Privacy Practices*, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below, if necessary:

Any member of my immediate family	Yes	No
Spouse only	Yes	No
Others (please specify)	Yes	No

Name of Patient: _____

Signature of Patient (or Guardian): _____

Date: _____

Dependent family members also covered by this acknowledgement:

_____

_____

FOR OFFICE USE ONLY
We were unable to obtain the patient's written acknowledgement of our Notice of Privacy Practices due to:

- Patient's refusal to sign
  ___ needed more time to review Notice of Privacy Practices
  ___ wanted to consult with another person before signing
  ___ unable to sign
- Communication barrier
- Emergency situation
- Other

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com

PINE LAKE DENTAL CARE
NOTICE OF PRIVACY PRACTICES

We understand that information about you and your health is very personal and 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 be sensitive about and to respect the confidentiality of your healthcare information is never compromised. We may amend our privacy policies and practices, but you will always be informed 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 (HIPPA) and the state of Washington. This includes issues relating to your treatment, payment, and our dental 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.

Collecting Protected Health Information

We will only request personal information needed to provide our standard of quality dental care, implement payment activities, conduct normal dental 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 our information for marketing purposes without your written consent.

We may use/disclose your health information to communicate reminders about your appointments including voicemail and answering machine messages, emails and postcards.

Patient Rights

You have the right to request copies of your health care information. All such requests must be in writing. We may charge you for your copies the 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 let us know if you have any questions regarding your privacy rights and the protection of your personal health information.

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com

PINE LAKE DENTAL CARE
MEDICAL HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Although dental providers primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have or medications that you are taking could have an important interaction with the dentistry you will receive. Thank you for answering these questions:

PHYSICIAN'S NAME: _____ **PHYSICIAN'S PHONE NUMBER:** _____

	YES	NO	If yes, please explain:	MEDICATIONS:
Are you under a physician's care now?	☐	☐	_____	_____
Have you ever been hospitalized?	☐	☐	_____	_____
Have you ever had a serious head/neck injury?	☐	☐	_____	_____
Have you ever been on bisphosphonate therapy? (Fosamax, Actonel, Boniva, Didronel, Skelid)	☐	☐	**If yes, for how long?** _____	_____

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

☐ Local anesthetic "Novocaine"	☐ Codeine, Demerol, other narcotic	☐ Latex or rubber dam	☐ Sulfa drugs
☐ Penicillin or other antibiotics	☐ Aspirin, Acetaminophen, Ibuprofen	☐ Reaction to metals	☐ Other: _____

Do you have, or have you had, any of the following?

	YES	NO		YES	NO		YES	NO
AIDS/HIV Positive	☐	☐	Excessive Thirst	☐	☐	Pain in Jaw Joints	☐	☐
Alzheimer's Disease	☐	☐	Fainting Spells /Dizziness	☐	☐	Parathyroid Disease	☐	☐
Anaphylaxis	☐	☐	Frequent Cough	☐	☐	Psychiatric Care	☐	☐
Angina	☐	☐	Frequent Diarrhea	☐	☐	Radiation Treatment	☐	☐
Arthritis/Gout	☐	☐	Frequent Headaches	☐	☐	Renal Dialysis	☐	☐
Artificial Heart Valve	☐	☐	Glaucoma	☐	☐	Rheumatism	☐	☐
Artificial Joint	☐	☐	Hay Fever	☐	☐	Scarlet Fever	☐	☐
Asthma	☐	☐	Heart Attack / Failure	☐	☐	Shingles	☐	☐
Blood Disease	☐	☐	Heart Murmur	☐	☐	Sickle Cell Disease	☐	☐
Blood Transfusion	☐	☐	Heart Pace Maker	☐	☐	Sinus Trouble	☐	☐
Breathing Problem	☐	☐	Hemophilia	☐	☐	Stomach / Intestinal Disease	☐	☐
Bruise Easily	☐	☐	Hepatitis: Type _____	☐	☐	Thyroid Disease	☐	☐
Cancer	☐	☐	High Blood Pressure	☐	☐	Tuberculosis	☐	☐
Chemotherapy	☐	☐	Hives or Rash	☐	☐	Ulcers	☐	☐
Cold Sores/Fever Blisters	☐	☐	Hypoglycemia	☐	☐	Weight loss, unexplained	☐	☐
Congenital Heart Disorder	☐	☐	Irregular Heartbeat	☐	☐		**#per**	**Wk**
Cortisone/Steroid Treatment	☐	☐	Kidney Problems	☐	☐	Do you use Tobacco?		
Diabetes	☐	☐	Leukemia	☐	☐	Do you use Alcohol?		
Drug Addiction	☐	☐	Liver Disease	☐	☐	**Women :**	**YES**	**NO**
Emphysema	☐	☐	Low Blood Pressure	☐	☐	Are you pregnant?	☐	☐
Epilepsy or Seizures	☐	☐	Lung Disease	☐	☐	Are you nursing?	☐	☐
Excessive Bleeding	☐	☐	Mitral Valve Prolapse	☐	☐	Taking oral contraceptives?	☐	☐

Do you have any serious disease, condition or problem not listed above? If yes, please explain: _____

I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the dental office of any changes in my medical status.

SIGNATURE OF PATIENT, PARENT, OR GUARDIAN _____ ***DATE*** _____

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com

PINE LAKE DENTAL CARE
DENTAL HISTORY

PATIENT NAME: _____ **DATE OF BIRTH:** _____

Reason for today's visit: _____	Date of Last Dental Exam: _____	Date of Last Dental
Previous Dentist : _____	Date of Last Cleaning: _____	Treatment (other than a
How Long were you a patient? _____Years/Mos	Date of Last Dental X-rays: _____	Cleaning)? _____

Please answer YES or NO to the following questions:

PERSONAL HISTORY	**YES**	**NO**
Are you fearful of dental treatment?	☐	☐
Have you ever had an unfavorable experience or any complications with dental work?	☐	☐
Have you ever had trouble getting numb or reactions to local anesthetic?	☐	☐
Have you ever had braces? Gum treatment/surgery? Teeth extracted?	☐	☐

SMILE CHARACTERISTICS	**YES**	**NO**
Are you dissatisfied with the appearance of your teeth?	☐	☐
Have you been disappointed with the appearance of previous dental work?	☐	☐
Have you ever whitened your teeth?	☐	☐

BITE AND JAW JOINT	**YES**	**NO**
Do you have any discomfort when chewing?	☐	☐
Do you experience any problems with sleep or wake up with headaches or sore teeth?	☐	☐
Do you have problems with your jaw joint? (pain, clicking, limited opening, locking)	☐	☐
Have you been told or do you suspect that you grind/clench your teeth?	☐	☐
Do you wear or have you ever worn a night guard?	☐	☐
Have you noticed that your teeth have changed in the past few years, becoming more worn?	☐	☐
Are you aware of an uncomfortable bite?	☐	☐
Have you ever experienced any trauma to the face/jaw (a blow, a ball hitting you, etc.)?	☐	☐

TOOTH STRUCTURE	**YES**	**NO**
Have you had any cavities in the past 3 years?	☐	☐
Do you have a dry mouth?	☐	☐
Are any teeth sensitive to hot, cold, biting or sweets?	☐	☐
Have you ever had a toothache, cracked filling, broken or chipped tooth?	☐	☐
Do you avoid chewing or brushing any part of your mouth?	☐	☐

GUM AND BONE	**YES**	**NO**
Have you ever been treated for gum disease or have had a deep cleaning?	☐	☐
Do your gums bleed when brushing, flossing or eating?	☐	☐
Have you noticed an unpleasant taste or odor in your mouth?	☐	☐
Have you experienced your gums receding away from the teeth?	☐	☐
Have you noticed that your teeth have become looser?	☐	☐
Do your parents or siblings wear dentures, have missing teeth or have periodontal disease?	☐	☐
Do you smoke? For how long and how many/day?	☐	☐

PATIENT SIGNATURE: _____ **DATE:**_____

Pine Lake Dental Care
22727 SE 29th Street • Sammamish, WA 98075
425-392-2103 • fax 425-313-9705
www.pinelakedentalcare.com