FIRST NAME_____LAST_____PREFERRED_____

ADDRESS_____

CITY/STATE/ZIP_____

EMAIL ADDRESS_____

DOB_____AGE_____ MALE / FEMALE

OCCUPATION_____EMPLOYER_____

SS#_____

HOME PHONE_____WORK PHONE_____CELL PHONE_____

INSURANCE PROVIDER_____

SUBSCRIBERS NAME_____DOB_____

EMPLOYER_____

ID NUMBER_____GROUP NUMBER_____

EMERGENCY CONTACT NAME AND PHONE_____

PHYSICIANS NAME AND PHONE_____

HOW DID YOU HEAR ABOUT US?_____

MEDICAL HISTORY- Do you, or have had , any of the following?

Abnormal Bleeding	YES/NO	Heart Disorder	YES/NO
AIDS/HIV Positive	YES/NO	Heart Attack	YES/NO
Alzheimer's Disease	YES/NO	Heart Murmur/Irregular beat	YES/NO
Anaphylaxis	YES/NO	Heart Pacemaker	YES/NO
Anemia	YES/NO	Heart Valve Replacement	YES/NO
Artificial Joint	YES/NO	Hemophilia	YES/NO
Artificial Heart Valve	YES/NO	Hepatitis	YES/NO
Bleed Easily	YES/NO	Herpes	YES/NO
Blood Disease	YES/NO	Hypoglycemia	YES/NO
Blood Transfusion	YES/NO	Immune System Disorder	YES/NO
Blood Pressure if yes,	HIGH/LOW	Injury Head/Neck/Mouth	YES/NO
Bruise easily	YES/NO	Kidney Problems	YES/NO
Cancer/Radiation	YES/NO	Liver Disease	YES/NO
Chemotherapy	YES/NO	Tumors	YES/NO
Chest Pains	YES/NO	Osteoporosis	YES/NO
Chronic fatigue	YES/NO	Psychiatric Treatment	YES/NO
Depression	YES/NO	Seizures	YES/NO
Diabetes	YES/NO	Shortness of Breath	YES/NO
Dizziness or Fainting	YES/NO	Stroke	YES/NO
Drug Addiction	YES/NO	Tuberculosis	YES/NO
Epilepsy	YES/No		

Other:_____

Medications- Are you taking any of the following medications?

Antibiotics	YES/NO
Insulin	YES/NO
Blood Thinners	YES/NO
Pain Medication	YES/NO
Heart Medication	YES/NO

Other (Prescription or Over the Counter):_____

Allergies- Do you have any of the following allergies?

Penicillin (antibiotics)	YES/NO
Aspirin	YES/NO
Latex	YES/NO
Codeine	YES/NO
Metals	YES/NO
Acrylic/Plastics	YES/NO
Local Anesthetic	YES/NO
Lidocaine	YES/NO

Other:_____

Do any of the following conditions apply to you?

Cold Sores	YES/NO	Mouth Sores	YES/NO
Digestive Problems	YES/NO	Nervousness	YES/NO
Difficulty Speaking	YES/NO	Nutritional Disorders	YES/NO
Difficulty Chewing	YES/NO	Numbness in lower lip	YES/NO
Dry Mouth	YES/NO	Pain in Jaw Joint	YES/NO
Facial Pain	YES/NO	Pain when Swallowing	YES/NO
Gagging Easily	YES/NO	Poor Circulation	YES/NO

Headaches	YES/NO	Poorly Fitting Dental Appliance	YES/NO
Jaw Joint Popping/Clicking	YES/NO	Prior Orthodontic Treatment	YES/NO
Limited Opening	YES/NO	Tingling or Numbness in Jaw	YES/NO
Limited/soft food diet	YES/NO	Teeth do not meet properly	YES/NO
Missing teeth not replaced	YES/NO		
Do you take Aspirin regularly?	YES/NO	Use Tobacco?	YES/NO
Are you currently Pregnant or nursing?	YES/NO		

Is there anything else you would like to share with us regarding your health?

Patient Signature:_____Date:_____

ACKNOWL EDGEMENT OF PRIVACY PRACTICES

Daniel McKay, DDS - Seattle, WA

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to:

Provide and coordinate my treatment among a number of health care providers who may be involved in that 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 healthcare 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 healthcare 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 of the *Notice of Privacy Practices*. Importantly the updated 9-23-13 version of the NOPP reflecting the OMNIBUS rule

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 and I 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.

Patient Name: _____ Date: _____

Signature: _____

Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

_____

Additional Disclosure Authority: (**concluded with discussion RE: patient etc.**)

OTHER-SPECIFY	Names	Signatures	ID	ETC.

For Office Use Only:

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

_____The patient refused to sign

_____Communication barriers

_____Emergency situation

_____ Other

OFFICE FINANCIAL POLICY

Dr. Daniel J. McKay
901 Boren Ave #1940
Seattle, WA 98104
206-381-3055

In our continued commitment to provide the highest quality of dental care available to all of our patients and to have those services comfortably affordable, we are pleased to offer you these payment options for payment.

- Patient Financing
- Visa or Master Card
- Care Credit
- 5% cash or check discount on date of service or appointments over $500.00

We are committed to support you in understanding your dental health, so that you will always be able to make the best choices. We will always present you with the best dental solutions possible to treat your personal situation.

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

I agree that I am fully responsible for the total payment of all procedures performed in this office- this includes any treatment that is not a benefit of any dental insurance that I may have. I understand that any estimated portion, not covered by insurance, is due at the time of service for all services regardless of whether or not my insurance benefits have been received. One percent (1%) monthly interest, twelve percent (12%) per year (per RCW 19.52) will be charged on accounts 60 days from the treatment date. I also understand that should credit be extended to me by this dental office, I authorize release of all financial data.

We are here to assist you in any way possible. Please make your questions and concerns known to our team. Our goal is to ensure that you have an outstanding experience. Thank you for giving us the opportunity to car for your dental needs.

_____ _____

(Signature) (Date)