O'BRIEN DENTISTRY
CAROL O'BRIEN, DDS

WELCOME TO OUR PRACTICE

"Let Your Smile Change The World"

On behalf of the entire team at O'Brien Dentistry, let us welcome you to our practice. We are grateful that you have chosen us for all of your dental needs, and trust you will find your experience in our office to be warm, friendly and professional. You may discover that we are different from the average dental practice. When you visit our office, you will find a unique and relaxing environment. Our team is friendly and attentive; ready to answer any questions or concerns you may have. We use the latest technology and techniques our profession has to offer.

In order to serve you better, we have enclosed several important forms that will assist us in making your transition to our office as smooth as possible. We ask that you read and complete all forms prior to your first visit and bring them with you so that we may utilize the full amount of time we have reserved for you. You can expect your visit to last approximately ninety minutes.

On your first visit with us, you can expect a thorough examination of your teeth, gums and mouth, looking for signs of disease or other problems. We will also take any x-rays needed to help diagnose anything that would otherwise go unnoticed. Our goal is to help you maintain good oral health and to prevent any problems from becoming serious, by identifying and treating them as soon as possible. Your overall health and wellness is important to us.

We are looking forward to meeting you and taking care of your dental needs. Please call us at any time, should you have any questions or concerns. Again, thank you for choosing O'Brien Dentistry and we will see you soon.

Sincerely,

The O'Brien Dentistry Team
Carol O'Brien, DDS

O'BRIEN DENTISTRY
CAROL O'BRIEN, DDS

WELCOME

Thank You for Selecting O'Brien Dentistry.

To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us and we will be happy to help.

1 Patient Information (Confidential)

Name _____ Patient Number _____

SS#/SIN _____ Birthdate _____ Date _____

Address _____ City _____ Home Phone _____

Email _____ State _____ Zip _____

When possible I prefer to be contacted via: ☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email ☐ Mail Cell Phone _____

Check Appropriate Box: ☐ Minor ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

If Student, Name of School/College _____ City _____ State _____ Zip _____

Patient or Parent/Guardian's Employer _____ Work Phone _____

Business Address _____ City _____ State _____ Zip _____

Spouse or Parent/Guardian's name _____ Employer _____ Work Phone _____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency _____ Phone _____

2 Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

Email _____ Cell Phone _____

Driver's License # _____ Birthdate _____ Financial Institution _____

Employer _____ Work Phone _____ SS#/SIN _____

Is this Person Currently a Patient in our Office? ☐ Yes ☐ No

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

☐ Cash ☐ Personal Check Credit Card ☐ VISA ☐ MasterCard ☐ AMEX ☐ Discover

3 Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS#/SIN _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Employer Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____ Policy ID # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

How Much is Your Deductible? _____ How Much Have You Used? _____ Max. Annual Benefit _____

4 Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

I hereby grant my healthcare provider permission to contact me via an automated phone/text/email system. I authorize my healthcare provider to disclose to third parties who answer my phone or have access to my communications my limited protected health information, and to leave a message on these devices.

X _____

Signature

_____

Date

O'BRIEN DENTISTRY
CAROL O'BRIEN, DDS

Confidential Patient Health History

Therapeutic Alert

PATIENT NAME _____ TODAY'S DATE _____

DATE OF BIRTH _____ AGE _____ PHONE# _____

IN CASE OF EMERGENCY, NOTIFY _____

Medical History

PHYSICIAN _____ DATE LAST PHYSICAL EXAM _____
(NAME & PHONE#)

Do you have or have you had any of the following? (Indicate with an X)

- ☐ Heart problems _____
  - ☐ Chest pain _____
  - ☐ Heart attack _____
  - ☐ Blood pressure problem _____
  - ☐ Heart murmur _____
  - ☐ Heart valve problem _____
  - ☐ Taking heart medication _____
  - ☐ Rheumatic fever _____
  - ☐ Pacemaker _____
  - ☐ Artificial heart valve _____
  - ☐ Stroke
- ☐ Blood problems _____
  - ☐ Easy bruising _____
  - ☐ Frequent nose bleeds _____
  - ☐ Abnormal bleeding _____
  - ☐ Blood disease (anemia, hemophilia) _____
- ☐ Allergy problems _____
  - ☐ Hay fever _____
  - ☐ Sinus problems _____
  - ☐ Skin rashes _____
  - ☐ Taking allergy medication _____
  - ☐ Asthma _____
- ☐ Intestinal problems _____
  - ☐ Ulcers _____
  - ☐ Weight gain or loss
  - ☐ Special diet _____
  - ☐ Colitis _____
- ☐ Bone or joint problems _____
  - ☐ Arthritis _____
  - ☐ Joint replacement (e.g., total hip) _____
- ☐ Fainting Spells _____
- ☐ Seizures or epilepsy _____
- ☐ Diabetes _____
- ☐ Cancer/tumor _____
- ☐ Hepatitis, jaundice or Liver Problems _____
- ☐ Kidney or bladder problems _____
- ☐ Spleen missing _____
- ☐ Tuberculosis or other respiratory disease _____
- ☐ Herpes _____
- ☐ HIV-positive, ARC or AIDS _____
- ☐ Glaucoma _____
- ☐ Wear contact lenses _____

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

- ☐ Local anesthetics (Novocaine) _____
- ☐ Penicillin or other antibiotics _____
- ☐ Sulfa drugs _____
- ☐ Barbiturates, sedatives, or sleeping pills _____
- ☐ Aspirin _____
- ☐ Codeine _____
- ☐ Latex _____
- ☐ Other _____
- ☐ Other _____

During the past 12 months have you taken any of the following?

- ☐ Antibiotics or sulfa drugs _____
- ☐ Anticoagulants (e.g., Coumadin) _____
- ☐ High blood pressure medicine _____
- ☐ Antianxiety medications _____
- ☐ Insulin, Orinase, or similar drug _____
- ☐ Aspirin _____
- ☐ Digitalis or drugs for heart trouble _____
- ☐ Nitroglycerin _____
- ☐ Cortisone (steroids) _____
- ☐ Other _____

Women

- ☐ Are you taking contraceptives or other hormones? _____
- ☐ Are you pregnant? _____
  If so, expected delivery date: _____
- ☐ Have any of your babies weighed more than nine pounds? _____
- ☐ Have you reached menopause _____
  If so, do you have any symptoms? _____

Do you have any disease, condition, or problem not listed previously that you feel we should know about? _____

_____

Please list any medication you currently take _____

_____

SIGNATURE _____

Dental History

Previous Dentist_____ Date Last Dental Exam _____
(NAME & CITY)

Chief Oral Concern_____

If dental treatment is needed, would you like the use of Nitrous Oxide (laughing gas)? ☐ YES ☐ NO

Do you have or do you use any of the following: (Indicate with an X)

- ☐ Apprehensive about dental treatment
- ☐ Sensitive teeth (cold, air, hot, sweets, pressure)
- ☐ Food impaction
- ☐ Bleeding gums
- ☐ Bad breath
- ☐ Unpleasant taste
- ☐ Clenching or grinding
- ☐ Pain around ears, neck or upper back
- ☐ Frequent headaches
- ☐ Unusual sounds in ear while eating
- ☐ Removable dental appliance
- ☐ Swelling or sores in your mouth
- ☐ Injury to face or jaws
- ☐ Oral habits, i.e. fingernail or cheek biting, gum chewing
- ☐ Mouth breathing
- ☐ Cigarettes, pipe or cigar smoking
- ☐ Use of tobacco, i.e. snuff
- ☐ Periodontal treatment
- ☐ Orthodontic treatment
- ☐ Endodontic treatment (root canal)
- ☐ Toothbrush
- ☐ Dental floss
- ☐ Water jet device
- ☐ Interdental cleaners
- ☐ Mouthwash
- ☐ Fluoride supplements, gel or rinse

SIGNATURE_____

O'BRIEN DENTISTRY
CAROL O'BRIEN, DDS

WRITTEN FINANCIAL POLICY

Thank You for choosing O'Brien Dentistry. We are committed to providing you with the highest quality dental care using the best material and technology available in the market today. We are also committed to providing you with up-to-date information and educational tools so that you can fully participate in maintaining optimum oral health. An important part of the mission is making the cost of your dental cares easy and manageable by offering several payment options.

Payment Options

You can choose from:

- Cash, Check, Visa, Mastercard, American Express, Discover and Care Credit

Please Note:

All charges you incur are your responsibility regardless of insurance coverage. We must emphasize that as your dental care provider, our relationship is with you, not your insurance company. Your insurance policy is a contract between you, your employer, and the insurance company. We can only estimate what an insurance company says benefits will be. If payment from your insurance company is not received within 60 days from the date of service, or they do not pay for the treatment rendered, you are responsible to pay the balance in full.

As a courtesy, we will help you process your insurance claims. You may direct your insurance company to pay your benefit directly to our office by signing the authorization on the Assignment of Benefits Agreement. In order for our office to file your insurance claims, you must bring a completed dental insurance form or proof of insurance to each appointment. All co-pays and/or out of pocket expenses are due at the time services are rendered.

For plans requiring multiple appointments, alternative payment arrangements may be provided.

If you have any questions, please do not hesitate to ask. We are here to help you get the best dentistry that you want and need.

Patient, Parent, or Guardian Signature Date

Patient Name (Please Print)

continued on back

O'BRIEN DENTISTRY
CAROL O'BRIEN, DDS

APPOINTMENT AGREEMENT for O'BRIEN DENTISTRY

Welcome to our practice. We are honored that you have selected us for all of your dental needs and wants.

We are committed to providing quality service to all our patients.

We believe that an important aspect of delivering exceptional dental care is our patients' committment to our practice as well.

Therefore, we request that you honor your reserved appointment as scheduled. Should you have to change your appointment for any reason, we ask that you give us 48 business hours notice. Otherwise, a charge of $50/hour will be incurred for the missed appointment. We appreciate your understanding in this matter.

Sincerely,

The O'Brien Dentistry Team

I have read, understand, and will honor the practice's Appointment Agreement:

Patient Signature Date

Carol A. O'Brien, DDS
3702 Bridgeport Way W, STE A
University Place, WA 98466
(253) 582-2408

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 Carol A. O'Brien, DDS. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Carol A. O'Brien, DDS, reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health care information to the persons indicated below.

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

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

Date | Description of Personal Representative's Authority

OFFICE USE ONLY BELOW THIS LINE

Record of Acknowledgement Not Obtained					
Provided Prior To Treatment?	☐	**YES**	☐	**NO**	
Date Provided:					
Reason for Denial:	☐	NEEDED MORE TIME TO REVIEW STATEMENT OF PRIVACY PRACTICES.			
	☐	WANTED TO CONSULT WITH ANOTHER PERSON, BEFORE SIGNING.			
	☐	UNABLE TO SIGN.			
	☐	REASON NOT GIVEN.			
	☐	**OTHER (EXPLAIN):**			

O'Brien Dentistry

Carol O'Brien, DDS

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. State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this notice. We must follow the privacy practices as described below. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this notice will be amended to reflect the changes and we will make the new notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our notice effective for all health information maintained, created, and/or received by us before the date changes were made. You may request a copy of our privacy notice at any time by contacting our privacy officer.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary" or "need to know" standards that limit various staff members access to your health information according to their primary job functions. Everyone of our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends, and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition, or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated, we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgement to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Health care operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our dental records staff, outside health or management reviewers and individuals performing similar activities.

Required by law: We may use or disclose your health information when required to do so by law, requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or neglect: We may use or 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. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health responsibilities: We will use or disclose your health information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence, or other national security activities, we may disclose it to authorized federal officials.

Appointment reminders: We may use or disclose your health information to provide you with appointment reminders including, but not limited to voicemail messages, text, email, postcards, or letters.

Your Privacy Rights As Our Patient:

Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact our privacy officer for a copy of the request form. You may also request access by sending us a letter. Once approved, an appointment can be made to review your records. Copies, if requested, will be $.50 for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary of an explanation of your health information, we will provide it for a fee. Please contact our privacy officer for a fee and/or for an explanation of our fee structure.

You have the right to amend your health care information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

You have the right to receive a list of non routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore they are not available). You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations.

You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies). Please contact our privacy officer if you want to further restrict access to your health care information. This request must be submitted in writing.

You have the right to file a complaint with us if you feel we have not complied with our privacy policies. Your complaint should be directed to our privacy officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. Request a complaint form from our privacy officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us.