PLEASE PRINT AND COMPLETE ALL INFORMATION BELOW AND BRING TO EXAMINATION APPOINTMENT

REGISTRATION FORM DATE _____

Patient Name _____
First M. Initial Last Name you like to be called

Birthdate _____/_____/_____ Age_____ ☐ Male ☐ Female ☐ Unmarried ☐ Married

Mailing Address _____ Cell Phone (_____)_____

City, State, Zip _____ Home Phone (_____) _____

Soc. Sec. # _____ E-mail _____

Employer _____ Occupation _____

Work Phone (_____) _____ Is it O.K. to call you at work? ☐ Yes ☐ No

Spouse's Name _____ Occupation _____

Employer _____ Work Phone (_____) _____

Whom may we thank for referring you? _____

In case of emergency, a local relative or friend to be notified (not living at same address).

Name _____ Relationship to Patient _____

Address _____ Phone (_____) _____

DENTAL INSURANCE INFORMATION

Primary Insurance Co. _____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Mailing Address _____ Insurance Co. Phone # (_____) _____

City, State, Zip _____ Insurance Group # _____

Subscriber's Name _____ Union Local # _____

Subscriber's ID# _____ Birthdate _____/_____/_____

Secondary Insurance Co. _____ Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Dependent

Mailing Address _____ Insurance Co. Phone # (_____) _____

City, State, Zip _____ Insurance Group # _____

Subscriber's Name _____ Union Local # _____

Subscriber's ID# _____ Birthdate _____/_____/_____

I give my consent for Dr. Sebastian and his staff to release any of my dental records to my insurance companies, physician, general dentist or any other doctor related to my care. I authorize release of any information to my medical and/or dental insurance companies relating to services with Dr. Sebastian. I authorize insurance payments to be directly made to Mark J. Sebastian DMD.

Both the above and the medical history on the reverse side are accurate. _____ Date _____/_____/_____
Signature (if patient is a minor, then parent or guardian)

TURN OVER ➟

Your present dentist _____ City _____ How long? _____

Last tooth cleaning _____

Have you ever had previous periodontal (gum treatment)? ☐ Yes ☐ No

When and by whom _____

Is there anything you want us to know regarding your dental treatment? ☐ Yes ☐ No

Describe _____

Name of physician _____ City _____ Phone _____

Check if you are allergic or have reacted adversely to any of the following?

☐ Dental anesthetics (Novacaine, etc.)	☐ Codeine	☐ Ibuprofen	☐ Sulfa drugs
☐ Penicillin/Amoxcilin	☐ Percodan / Percocet	☐ Aspirin	☐ Sulfite preservatives
☐ Barbiturates, sedatives, or sleeping pills	☐ Demerol	☐ Tylenol	☐ Latex
	☐ Vicodin	☐ Tetracycline	☐ Clindamycin
☐ Valium, Halcion, or other Benzodiazapenes	☐ Keflex/Cipro	☐ Erythromycin	☐ Iodine
☐ Other _____			☐ Sutures/stitches

Have you ever used intravenous (injected) bisphosphonates (Zometa, Aredia, Boniva, or Reclast)?_____

Have you ever had chemo therapy?_____

Are you now using or ever used oral (pill) bisphosphonates (Fosamax, Actonel, Atelvia, or Boniva)? _____

Have you ever been told you may need any antibiotic premedication for dental appointments?_____

Are you on any special diet? _____

Do you currently smoke? Y / N Amount _____ Smokeless tobacco / snuff? Y / N

Have you ever had extensive radiation therapy? _____

List all medications you are now taking (Rx, over the counter, or natural/herb supplements)_____

_____

Do you have or have you ever had any of the following diseases or problems?

PLEASE CHECK IF YES:

☐ Rheumatic fever	☐ Sleep disorder	☐ Sleep Apnea	☐ Cancer
☐ Rheumatic heart disease	☐ Seizures or epilepsy	☐ Kidney disease	
☐ Pacemaker	☐ Alcoholism	☐ Liver disease	
☐ Heart murmur	☐ Drug addiction	☐ Hepatitis A / B / C	
☐ Heart trouble	☐ Diabetes	☐ AIDS / HIV positive	
☐ High blood pressure	☐ Stomach ulcers	☐ Asthma	
☐ Artificial heart valves	☐ Arthritis	☐ Tuberculosis	
☐ Artificial joints	☐ Glaucoma	☐ Respiratory (Lung) disease	
☐ Prostate disorders	☐ Hemophilia	☐ Thyroid or parathyroid disorders	
☐ Anemia	☐ Bleeding disorders	☐ Osteoporosis/Osteopenia	
	☐ Depression/Bi-Polar/Schizophrenia	☐ Anxiety	

Please describe any other information you feel we should be aware of relative to your health: _____

_____

WOMEN:

Are you pregnant? ☐ Yes ☐ No If yes, expected delivery date _____

Do you think you might be pregnant?	☐ Yes	☐ No
Are you breast feeding?	☐ Yes	☐ No
Are you taking female hormones (oral contraceptives, etc.)?	☐ Yes	☐ No

PLEASE INFORM THE DOCTOR IF YOUR HEALTH CHANGES IN ANY WAY

Mark Sebastian DMD, PLLC
OUR FINANCIAL POLICY

The following is an outline of "Our Financial Policy". It is our intention to inform our patients as clearly and completely as possible as to our guidelines of payment for services rendered. It is our hope that openly discussing our financial policy will prevent future financial misunderstandings and allow us to concentrate on providing the highest quality dental care and service to our patients at a reasonable fee.

As a courtesy to you, we are happy to file the necessary insurance forms to see that you receive the full benefits of your coverage, however we make no guarantee of any estimated coverage. Because the insurance policy is an agreement between you and the insurance company, we ask patients to be responsible directly for all charges. Please know that we will do everything possible to see that you receive the full benefits of your policy. NOTE: PLEASE MONITOR YOUR BENEFITS AND ANNUAL MAXIMUM.

In order to keep our fees reasonable, **your estimated patient portion is due at the time services are rendered.** Because we cannot guarantee your exact insurance coverage, there may be a balance remaining after insurance payment is received.

Payments can be made with cash, check, Visa or Mastercard. CareCredit Financing is an option for a long-term payment plan. Also, we offer a 5% discount on payments in full on the day services are rendered (not offered in conjunction with CareCredit or in-network insurances).

There will be a $35.00 fee on all returned checks unpaid by your bank due to NSF. At 90 days from the date of service, any account balance will be assessed interest at 1% per month (12% APR). Delinquent accounts will be referred to collections after 90 days unless previous arrangements have been made.

Please remember that once an appointment has been made, this time is reserved specifically for you. If you need to change or cancel your appointment, we kindly request at least 48 business hours notice**.**
Hygiene appointment cancellations made less than 48 hours prior to your scheduled appointment and missed appointments are subject to a $79 fee.
Surgical appointment cancellations made less than 48 hours prior to your scheduled appointment and missed appointments are subject to a $195 fee.

If you have any questions or concerns feel free to contact our office at
(253) 941-6242 or (253) 952-2005.

Signed _____ Date _____

33516 9th Ave. So. Bldg. #2 Federal Way, WA 98003 www.MarkSebastianDMD.com

Mark Sebastian DMD, PLLC
AUTHORIZATION FOR USE OF PUBLIC E-MAIL

I hereby authorize Dr. Sebastian and staff to use public e-mail for the sake of transmitting any protected dental health information, photos, x-rays, etc. that pertain to my dental treatment. Such communication may be sent to myself (the patient), other healthcare providers, insurance companies, and dental product representatives that Dr. Sebastian deems necessary.

I understand that e-mail has a number of risks, which include, but are not limited to, the following:

- E-mail can be immediately broadcast worldwide and received by many intended and unintended recipients.
- E-mail senders can misaddress an e-mail.
- Backup copies of e-mail may exist even after the sender or the recipient has deleted his or her copy.

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the HIPAA Privacy Officer of Dr. Sebastian at 33516 9th Avenue South, Suite 2, Federal Way, WA 98003.

I understand that I have the right to

- Inspect or copy my protected health information to be used or disclosed as permitted under federal and/or state law.
- Refuse to sign this authorization

I understand that Dr. Sebastian will not condition my treatment on whether I provide authorization for the requested use of disclosure.

_____ _____

Signature of Patient or Personal Representative Date

_____

Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

STATEMENT OF PRIVACY PRACTICES

MARK J SEBASTIAN, DMD

Our office is dedicated to protect the privacy rights of our patients and the confidential information entrusted to us. It is a requirement of this practice that every employee receive appropriate training and is dedicated to the principal concept that your health information shall never be compromised. We may, from time to time, amend our privacy policies and practices but will always inform you of any changes that might affect our obligations and your rights.

PROTECTING YOUR HEALTHCARE INFORMATION

We use and disclose the information we collect from you only as allowed by the Health Insurance Portability and Accountability Act and the state of Washington. This includes issues relating to your treatment, payment, and our health care operations. Your personal health information will never be otherwise given or disclosed to anyone – even family members – without your consent or written authorization. You, of course, may give written authorization for us to disclose your information to anyone you choose, for any purpose.

Our offices and electronic systems are secure from unauthorized access and our employees are trained to make certain that the confidentiality, integrity, and access to your records is always protected. Our privacy policy and practices apply to all former, current, and future patients, so you can be confident that your protected health information will never be improperly disclosed or released.

COLLECTING PROTECTED HEALTHCARE INFORMATION (PHI)

We will only request personal information needed to provide our standard of quality health care, implement payment activities, conduct normal health 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 HEALTHCARE 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 your information for marketing or fund-raising purposes without your written consent. We may use and/or disclose your health information to communicate reminders about your appointments including voicemail messages, answering machines, and postcards unless you direct us otherwise. We will never use, disclose, sell, or otherwise allow access to your personal, protected information in exchange for or receipt of financial remuneration.

Any breach in the protection of your personal health information, including unauthorized acquisition, access, use, or disclosure, will be fully investigated, addressed, and mitigated as established by the HIPAA Privacy Breach Notification Rule. You have a right to and will be provided all information relating to any breach involving your personal PHI

YOUR RIGHTS AS OUR PATIENT

You have a right to request copies of your healthcare information; to request copies in a variety of formats; and to request a list of instances in which we, or our business associates, have disclosed your protected information for uses other than stated above. All such requests must be in writing. We may charge for your copies in an 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.

An expanded, and complete copy of our Statement of Privacy Practices, is available for your review.

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Mark J Sebastian, DMD. 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.

Mark J Sebastian, DMD reserves the right to change the privacy practices currently 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 or otherwise transmitted to me.

ADDITIONAL DISCLOSURE AUTHORIZATION		
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my Protected Healthcare Information to the person(s) identified below. (I understand that the default answer is "NO". Without indicating "YES" in answer to each individual question, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)		
Spouse only	**☐ YES**	**☐ NO**
OR		
Any Member of my immediate family: (i.e. Spouse, Children, Siblings, etc.)	**☐ YES**	**☐ NO**
Any Member of my extended family: (i.e. Parents, Grandchildren)	**☐ YES**	**☐ NO**
Other:	**☐ YES**	**☐ NO**
Name of patient (please print):		
Patient signature:		
Patient's personal representative: (Please Print):		
Personal Rep's signature:		
Representative's Phone Number:	Date:	

OFFICE USE ONLY BELOW THIS LINE

Acknowledgement Not Obtained			
Provided Prior to Treatment?	☐ YES	☐ NO	Date Statement Provided: _____
Reason for not obtaining patient signature	☐	Needed more time to review Statement	
	☐	Wanted to consult another person before signing	
	☐	Physically unable to sign	
	☐	No reason offered	
	☐	Other:	